Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 24, 2018	2018_563670_0010	005994-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Blenheim Community Village
10 Mary Avenue BLENHEIM ON N0P 1A0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DEBRA CHURCHER (670), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 14, 15, 16, 17 and 18, 2018.

Inspector Cassandra Taylor #725 attended this inspection.

The following Critical Incident System reports (CIS) were inspected during this RQI:
Log# 024397-17 CIS #2695-000023-17 related to a fall with injury.
Log# 000342-18 CIS #2695-000001-18 related to a fall with injury.
Log# 029665-17 CIS #2695-000030-17 related to a fall with injury.
Log# 001134-17 CIS #2695-000002-17 related to a fall with injury.
Log# 006774-17 CIS #2695-000006-17 related to a fall with injury.
Log# 031337-16 CIS #2695-000030-17 related to an unexpected death.
Log# 026877-16 CIS #2695-000016-16 related to alleged staff to resident abuse.
Log# 026868-16 CIS #2695-000017-16 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, Residents' Council representative, the Executive Director, the Director of Care, the Registered Dietitian, the Assistant Director of Care, six Registered Practical Nurses, two Registered Nurses, nine Personal Support Workers, and more than three family members.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, dining, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records and the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, outlining an incident that caused an injury to resident #009.

Resident #009 was identified to be at high risk for a specific event. Documentation in the plan of care included several interventions that the resident was to have in place.

On a specific date at a specific time, resident #009 was observed in their room, and a specific intervention was not in place.

Personal Support Worker (PSW) #117 stated during interview that resident #009 should have had the intervention in place.

On a specific date at a specific time, resident #009 was again observed in their room and a specific intervention was not in place.

Director of Care (DOC) #111 stated that the specific intervention should have been in place.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #009. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Review of the home's medication incident reports for a specific time frame, showed a medication incident dated for a specific date, medication incident record (MIR) #07467, related to the administration of a dose of a specific medication to resident #014 that had not been prescribed.

The medication incident dated for a specific date, MIR #074467, stated that resident #014 had been ordered to have a specific medication one time on a specific date. Review of the electronic Medication Administration Record (eMAR) showed that Registered Practical Nurse #112 had administered the specific medication a second time.

On May 17, 2018 at 1220 hours, an interview was conducted with Director of Nursing (ADOC) #111 who stated that a drug had been administered to resident #014 that had not been prescribed.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the home's medication incident reports for a specific date, showed two medication incident reports dated for a specific date, medication incident record (MIR)

#07406 and 07407, related to an order for the administration of two specific drugs to resident #014 that were not administered.

a)The medication incident report dated for a specific date, MIR #07406, stated that resident #014 was ordered an increase in a specific medication at a specific time daily. The medication incident report indicated that the order was missed being processed and the resident did not receive the specific medication until a specific date.

b) The medication incident report dated for a specific date, MIR #07407, stated that resident #014 was ordered a specific medication twice daily. The medication incident report indicated that the order was missed being processed and the resident did not receive the the specific medication until a specific date.

On May 17, 2018 at 1220 hours, an interview was conducted with Director of Nursing (DOC) #111 who stated that drugs were not administered to resident #014 in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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Issued on this 11th day of June, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.