



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2015	2015_276537_0033	011693-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens 710 Southdale Road East LONDON ON N6E
1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST LONDON ON N6E 1R8

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

NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 11 and 12, 2015

The following Critical Incident inspections related to Medication were completed.

Log # 011693-15/CI M514-000021-15

Log # 019140-15/CI M514-000031-15

During the course of the inspection, the inspector(s) spoke with the Director of Care, two Assistant Directors of Care and the Dietary Manager.

The inspector(s) also observed residents and care provided to them, a medication pass, reviewed health care records and plans of care for identified residents, policies and procedures.

**The following Inspection Protocols were used during this inspection:
Medication**

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

2 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).



Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A) Record review for an identified resident indicated the administration of a medication for pain per a physician order was not completed on two occasions as the drug was not available.

Record review for this resident did not include an assessment or evaluation of the Resident's pain as a result of not receiving medication as ordered.

The home's policies revealed that the home had a process in place to reorder medications to ensure medications were available for administration and a process to evaluate the effectiveness of the medications.

The Assistant Director of Care verified that the medication was not administered as it had not been reordered as per policy and that a pain assessment had not been completed as per policy.

B) A progress note for an identified resident indicated that despite the administration of PRN medications for pain, the resident verbalized ongoing pain with no relief.

The home's policy revealed a process for notification to the required disciplines for assessment when a resident's pain was uncontrolled using current therapeutic regimes.

The Assistant Director of Care verified that the home's process was not followed when the pain of this resident was assessed as uncontrolled.

The Director of Care and the Assistant Director of Care confirmed that the expectation is that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1) (b)]

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. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Record review for an identified resident revealed the administration of a medication that was not in accordance with the directions for use specified by the prescriber, specifically did not follow the time guidelines for administration.

The Director of Care verified that the medication was not administered within the specified time guidelines and the expectation was medications were to be administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 14th day of August, 2015

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

Original report signed by the inspector.