Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: November 8, 2024

Inspection Number: 2024-1045-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Hillside Manor, Stratford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 29, 30, 31, 2024 and November 5, 2024
The inspection occurred offsite on the following date(s): November 4, 6, 2024
The following intake(s) were inspected:

- Intake: #00127208 – Critical Incident #1975-000022-24, related to an outbreak
- Intake: #00128322 – Complaint related to cytotoxic medication precautions
- Intake: #00130716 - Critical Incident #1975-000024-24, related to an outbreak

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe environment for a resident when cytotoxic medication precautions were not in place.

Rationale and Summary

A resident started receiving a cytotoxic medication and there were directions from pharmacy in the medication administration record for registered staff related to the proper handling of the medication. For a 13 month period of time, there were no other directions to staff, and appropriate cytotoxic procedures were not in place for handling and disposal of garbage or linens, use of personal protective equipment (PPE) during care or cleaning, or cleaning the bathroom after resident use, to minimize the risk of exposure to the cytotoxic medications by the resident's room mate or staff.

After the home discovered the appropriate precautions were not in place, precautions were implemented and training was provided to staff. However, as of the time of the inspection, a month after the home had identified the deficiencies, 50% of staff had still not received the training. The home did not have a process in place to ensure that all staff had received the training related to cytotoxic medication precautions.

There was risk that a resident was exposed to cytotoxic medications that were ordered for their room mate, when appropriate precautions were not in place for 13 months.

Sources: Health records for a resident, resident and staff interviews, and policies and procedures.