Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 14, 2014	2014_260521_0005	L-000961-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

STIRLING HEIGHTS
200 STIRLING MacGREGOR DRIVE, CAMBRIDGE, ON, N1S-5B7

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

REBECCA DEWITTE (521)

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): January 15, 16, 2014

During the course of the inspection, the inspector(s) spoke with the Medical Director, Administrator, Director of Care, Assistant Director of Care, 1 Registered Nurse, 1 Registered Practical Nurse, 1 Secretary and 2 Residents.

During the course of the inspection, the inspector(s) reviewed the clinical records of 2 Residents, reviewed policy LTC-B-60 and IPC-I-10.

The following Inspection Protocols were used during this inspection:

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

Critical Incident Response
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices as evidenced by:

A) A Resident returned from hospital with a low grade fever and was failed to be monitored.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that a Resident was reassessed and the care plan was reviewed and revised when the resident's care needs changed as evidenced by:

A) Resident returned from hospital in 2013 with a significant change of health status. The care plan was partially revised by staff but not completed.

B) In January, 2014 the inspector received a hand written care plan emailed from the staff of the Long Term Care Facility. This care plan differs from the original one received during the initial inspection in the following ways:

1) It has a different physician responsible for the Resident.

2) It does not include the partial update by staff in 2013.

3) It fails to identify who made the hand written alterations. [s. 24. (9)]

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 residents are reassessed and care plans reviewed and revised when a resident's care needs change, to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy, protocol, strategy is complied with as evidenced by:

A) Policy - Infection Prevention and Control Index IPC - I -10 Immunization of Residents, dated April 2013. Page 3 section 14 states document each residents vaccine administration information in the Residents health record. Documentation must include the date and time the vaccine was administered.

Upon review conflicting documentation noted in a Resident clinical record. The medication administration order indicates to give Fluad Influenza Vaccine - Intramuscular, 0.5ml everyday.

Documentation reveals Fluad Influenza Vaccine was given on a date in 2013 in the Point Click Care progress note and on a different date in 2013 in the Medication Administration Record. The staff confirmed conflicting documentation. [s. 8. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

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Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident that caused an injury in respect of which a person is taken to hospital as evidenced by:

A) A Resident sustained a fall and was transferred to the hospital in 2013. Initial report submitted to the Director late. The Director of Care confirmed that the report was not submitted within the mandated time frames. [s. 107. (3) 4.]

Issued on this 10th day of March, 2014

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

REBECCA DEWITTE