Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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 performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 10, 11, 15, 16, 18, 25, 29, 30, 31, 2012	2012_174189_0002	Complaint

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

ELGINWOOD
182 YORKLAND STREET, RICHMOND HILL, ON, L4S-2M9

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Registered Staff

**During the course of the inspection, the inspector(s) Conducted walk through of common and resident areas
Reviewed health care records
Reviewed Medication and Admissions Policies**

The following Inspection Protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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
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. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident's plan of care is based on an interdisciplinary assessment of the resident's health conditions including pain, drugs and treatment(r. 26(3)10, 17)

Review of resident's record and staff interviews confirm the following:

On December 26, 2011, at 2140h, resident #1 returned from hospital with a diagnosis of urinary infection. Resident #1 was treated in hospital with Intravenous (IV) antibiotic and was sent back to the home with a prescription to continue oral antibiotic.

The antibiotic medication was not obtained and the resident deteriorated and was sent back to hospital on December 28, 2011.

The licensee did not follow their usual protocol to contact physician and obtain prescription for the medication. This resulted in the resident not receiving the medication as planned.

Issued on this 5th day of November, 2012

[redacted]

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

Nicole Rapp