



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 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
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jul 18, 24, 2012; 2012_046166_0033; Critical Incident

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

RIVERVIEW MANOR NURSING HOME
1155 WATER STREET, PETERBOROUGH, ON, K9H-3P8

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of Care.

During the course of the inspection, the inspector(s) reviewed clinical documentation and the licensee's documented investigation.

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. 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



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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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

- 1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.**
- 2. An unexpected or sudden death, including a death resulting from an accident or suicide.**
- 3. A resident who is missing for three hours or more.**
- 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.**
- 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.**
- 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

Findings/Faits saillants :

the licensee failed to notify the Director immediately related to an identified resident who had been missing from the home greater 3 hours. [s.107.(1)3.]

Issued on this 25th day of July, 2012

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