



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

**Rapport d'inspection
prevue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

London Service Area Office
291 King Street, 4th Floor
London, ON N6B 1R8

Bureau régional de services de London
291, rue King, 4^e étage
London, ON N6B 1R8

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

Telephone: 519-675-7680
Facsimile: 519-675-7685

Téléphone: 519-675-7680
Télécopieur: 519-675-7685

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
Sept 08 & 09, 2010	2010_112_2573_08Sep121611	Critical Incident L00936

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga. ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Sumac Lodge, 1464 Blackwell Road, Sarnia, ON N7M 5M4

Name of Inspector
Carole Alexander Inspector #112

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, and 2 Registered staff

During the course of the inspection, the inspector: Reviewed the home's process for drug ordering and receiving, narcotic count system. Reviewed the home's contract for pharmacy services. Reviewed home's resident identification system. Reviewed staff education related to medication administration processes. Reviewed resident MAR and progress record.

The following Inspection Protocols were used in part or in whole during this inspection:
Medication Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 VPC



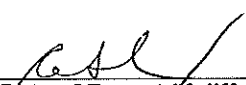
WN #1: The Licensee has failed to comply with Ontario Regulation 79/10 s. 131 (1)
Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Findings:
A resident received a medication which was not prescribed by the physician.

Inspector ID #: 112

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 with ensuring proper drug identification prior to administration, to be implemented voluntarily.

<p>Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné</p>	<p>Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.</p> 
<p>Title: _____ Date: _____</p>	<p>Date of Report (if different from date(s) of inspection).</p>