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

Rapport d'inspection prévue 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

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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	Licensee Copy/Copie du Titulaire	x Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection August 30, 2010	**Inspection No/ d'inspection** 2010-168-2742-29-Aug181736	**Type of Inspection/Genre d'inspection** Other – Critical Incident H-00823

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
Telfer Place
245 Grand River Street North
Paris ON N3L 3V8

Name of Inspector/Nom de l'inspecteur
Lisa Vink

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Other – Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with:
The charge RN, ADOC and Administrator

During the course of the inspection, the inspector:
Reviewed the residents clinical record, interviewed the resident, and reviewed the relevant procedure.

The following Inspection Protocols were used during this inspection:
Ad Hoc notes

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

[3] WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

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

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, s. 107(3)5
The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

Findings:
The home submitted a Critical Incident Report for a medication incident in which the identified resident was taken to the hospital 3 days after the incident occurred. The home had no previous contact with the Director regarding this incident until the Critical Incident Report was submitted.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, s 131(2)
The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:
The identified resident was administered a double dosage of specific medications which is not in accordance with the directions as prescribed.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, s 8(1)(b)
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, is complied with.

Findings:
The home has Procedure "Medication/Treatment Administration Records - LTC-G-90" which indicates "When a registered staff administers medication/treatment, this person must initial MAR/TAR sheet under correct date and time of administration."
On the date that the identified medication incident occurred the RN did not initial on the Medication Administration Record at the time the medications were administered, as required in the homes procedure.

Inspector ID#: 168

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	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. October 12·2010 - [signature]
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).