

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
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Date(s) of inspection/Date(s) de l'inspection No/ No de l'inspection Type of Inspection/Genre d'inspection
Sep 9, 13, 2011 2011_046166_0032 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

REACHVIEW VILLAGE

conformité

130 REACH STREET, UXBRIDGE, ON, L9P-1L3

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 Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Resident, the Director of Care, a member of the Registered Nursing staff, and a Personal Support Worker.

During the course of the inspection, the inspector(s) observed the Resident and reviewed the resident's clinical health care records.

The following Inspection Protocols were used in part or in whole during this inspection: Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction	WN – Avis écrit VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO - Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care Specifically failed to comply with the following subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits sayants:

1. Clinical documentation and interview with the Director of Care confirm that the resident's Power of Attorney was not notified of the resident's transfer to hospital for further assessment.

WN #2: 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. (3) 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):
- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
- 3. A missing or unaccounted for controlled substance.
- 4. An injury in respect of which a person is taken to hospital.
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits sayants:

1. The resident, sustained an injury and the licensee did not inform the Ministry of the incident as required under the legislation [r.107.(3)4.]

Issued on this 13th day of September, 2011



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