



**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 sous la Loi de 2007 sur les foyers de soins de longue durée**

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch**

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

**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|--------------------------------|--|
| Sep 2, 2014                                    | 2014_181105_0033                              | L-000563-14                    | Critical Incident System                           |

**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**

THE VILLAGE SENIORS COMMUNITY  
101-10TH STREET, HANOVER, ON, N4N-1M9

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

JUNE OSBORN (105)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): September 2, 2014**

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

**During the course of the inspection, the inspector(s) reviewed the clinical record.**

**The following Inspection Protocols were used during this inspection:**

- Critical Incident Response**
- Responsive Behaviours**



**Findings of Non-Compliance were found during this inspection.**

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



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**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:**

**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. O. Reg. 79/10, s. 107 (3).**

**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**

**i. a breakdown or failure of the security system,**

**ii. a breakdown of major equipment or a system in the home,**

**iii. a loss of essential services, or**

**iv. flooding.**

**O. Reg. 79/10, s. 107 (3).**

**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**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).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of the incident of: 4. an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A Resident was involved in an incident, and the Director was not notified within one business day as required.

The Director of Care acknowledged, in the Critical Incident notes, that this was a late submission.

The Administrator confirmed this report had been submitted late. [s. 107. (3)]



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**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
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**Issued on this 2nd day of September, 2014**

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