Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 16, 2015	2015_389601_0025	029518-15	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
130 REACH STREET UXBRIDGE ON L9P 1L3

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 12 and 13, 2015.

Related to log# 029518-15 and critical incident # 2635-000028-15.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers,identified
Resident and a resident's family member.

The inspectors observed resident care including staff-resident interactions, medication pass,
and reviewed resident's health care records, a critical incident and compliance history.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
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
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:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care for resident #001 was based on an assessment of the resident and the resident's needs and preferences.

Resident #001's plan of care was updated on an identified date by RN#102 indicating to ensure that the resident's medication is administered in the hallway.

On an identified date and time resident #001 was resting on the bed when RPN#101 approached the resident to administer medication. RPN#101 indicated that resident #001’s medication has been previously found in the bed and requested resident #001 come to the hallway to receive medication. Resident #001 became angry and indicated that RPN#101 could not refuse to give medication in the resident’s room and would be calling a lawyer.

Review of resident #001's plan of care at the time of the incident indicated to ensure medication was administered in the hallway. During an interview, RPN#101 indicated that resident #001 plan of care was to administer medication in the hallway and the resident did become angry when asked to come into the hallway to receive medication.

During an interview, resident #001 indicated a preference of taking the medication when needed whether it is in the hallway or in the resident’s room. Also, resident #001 indicated that RPN#101 had no right to request the resident come to the hallway to take the medication. [s. 6. (2)]

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 to ensure the plan of care for resident #001 is based on an assessment of the resident and the resident's needs and preferences specific to medication administration, to be implemented voluntarily.

Issued on this 16th day of November, 2015

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

Original report signed by the inspector.