Ontario

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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2013	2013_049143_0025	O-001410-12	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

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

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

PAUL MILLER (143)

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): May 8th-10th, 2013.

The following Critical Incident Reports were reviewed as part of this inspection: Critical Incident System(CIS) #2635-000007-12 (Log # O-001410-12), CIS #2635-000002-13 (Log # O-000019-13) and CIS #2635-000019-12 (Log # O-002086-12)

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Assistant Director of Care, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, inclusive of plans of care, assessments, policies and procedures related to abuse, fall prevention, continence care, missing resident and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	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

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The following findings are in respect of Log # O-001410-12:

On a specified date resident # 3 was transferred to a bathroom by a Personal Support Worker (#S107). The resident was left unattended and fell striking their head. Resident #3 was transferred to hospital. A review of resident #3's plan of care indicated that the resident is a two person side by side transfer. Interviews with the Director of Nursing as well as three Personal Support Workers indicated that it is the homes practice to ensure that all residents that require a two person transfer have one staff remain in the immediate area to ensure resident safety.

The licensee has failed to comply with the Long Term Care Homes Act section 6. (7) by not ensuring that the care set out in the plan of care is provided to the resident. [s. 6. (7)]

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Issued on this 10th day of May, 2013

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