



**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**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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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
Jun 29, 2015	2015_327570_0019	O-001731-15; O-002135-15	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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): June 22 and 23, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist and Residents.

The inspector also reviewed Critical Incident Reports #2871-000002-15 and #2871-000004-15, reviewed resident's health care records, reviewed the home's internal investigation documents, reviewed employee training documents, observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.

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).**

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

- 2. A description of the individuals involved in the incident, including,
 - i. names of any residents involved in the incident,**
 - ii. names of any staff members or other persons who were present at or discovered the incident, and**
 - iii. names of staff members who responded or are responding to the incident.**O. Reg. 79/10, s. 107 (4).**

Findings/Faits saillants :



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

The following finding is related to Critical Incident Inspection Log #O-002135-15

On an identified date, Resident #02 was transferred to hospital for assessment and treatment of a significant condition. The resident returned to the home on the same day.

On an identified date, inspector #570 reviewed the incident related to Resident #02's condition and transfer to hospital with the Executive Director (ED). The ED confirmed that the Critical Incident Report should have been submitted to the MOHLTC no later than one business day of the resident's diagnosis and transfer to hospital. [s. 107. (3)]

The Critical Incident Report related to Resident #02 was submitted to the MOHLTC thirteen days post incident.

2. The licensee has failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

The following finding is related to Critical Incident Inspection Log #O-002135-15

On an identified date, inspector #570 reviewed the incident related to Resident #02 with the Executive Director (ED). The ED confirmed that the names of the Personal Support Workers involved with incident were not included in the Critical Incident Report submitted to the MOHLTC on an identified date. [s. 107. (4) 2.]



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Issued on this 29th day of June, 2015

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

Original report signed by the inspector.