

**Ministry of Health
and Long-Term Care**

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
Facsimile: 613-569-9670

**Ministère de la Santé
et des Soins de longue durée**

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4^{ième} étage
Ottawa ON K1S 3J4
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February 23, 2011

Ms. Beverley Rayside
Administrator
Winbourne Park
1020 Westney Road North
Ajax ON L1T 4K6

Dear Ms Rayside:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on November 18, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely

A handwritten signature in cursive script, appearing to read "Lynda Brown".

Lynda Brown
LTC Home Inspector – Nurse

c President, Resident's Council
President, Family Council



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

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 18, 2010	2011_111_2871_26Jan1325	Critical Incident (Log # O-002292)

Licensee/Titulaire

Revera Long Term Care Inc.,
55 Standish Court, 8th Floor
Mississauga, ON L5R 4B2
Fax: 289-777-1406

Long-Term Care Home/Foyer de soins de longue durée

Winbourne Park,
1020 Westney Road North,
Ajax, ON L1T 4K6
Fax: 905-426-6297

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

Lynda Brown, ID # 111

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to a deceased resident.

During the course of the inspection, the inspector spoke with the Program Manager, Director of Care and the Executive Director.

During the course of the inspection, the inspector reviewed the resident's health record.

The following Inspection Protocols were used during this inspection: Medication, Critical Incident and Ad Hoc notes.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.reg.79/10, s.131 (2) The licensee shall ensure that drugs are administered to residents in accordance with the direction for use specified by the prescriber.

Findings:

-An identified resident was not administered medications in accordance with the direction for use as specified by the prescriber which resulted in a change in medical status.

Inspector ID #: 111

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 ensuring residents are administered medications as specified by the prescriber.

WN #2: The Licensee has failed to comply with O.Reg.79/10,s.8 (1)(a)(b) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan , policy, protocol, procedure, strategy or system,

- (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act:
- and
- (b) is complied with

Findings:

-An identified resident did not have documentation completed according to the homes policy and procedure for Narcotics and Controlled Substances
 -An identified resident did not have documentation completed according to the homes policy and procedure for Processing Order Changes or Discontinuations

Inspector ID #: 111

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 that the homes policy for narcotic and controlled drugs and processing order changes or discontinuations is complied with.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title:		Date of Report: (if different from date(s) of inspection).
Date:		<i>Lynda Brown</i> <i>February 17, 2011</i>