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
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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
Mar 14, 2013	2012_104196_0051	S-001353-12,S-001354-12	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

ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

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

LAUREN TENHUNEN (196)

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): December 20, 21, 2012

Ministry of Health and Long-Term Care (MOHLTC) Log#: S-001353-12,S-001354-12
Critical Incident reports

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nursing staff (RN and RPN), Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s) conducted a walk through tour of all resident home areas, observed the provision of care and services to residents, reviewed the health care records of several residents

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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.)	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Two Critical Incident reports were submitted to the Ministry of Health and Long-Term Care (MOHLTC) in November 2012, outlining two separate altercation incidents between resident #001 and resident #002. In both Critical Incident reports, resident #002 had wandered and entered the room of resident #001, which resulted in an altercation. According to the reports, in order to redirect resident #002 away from the room of resident #001, an sensor alarm was installed on the doorway and a wander barrier was applied to the door. An interview was conducted on December 21, 2012 with staff member #100 and it was reported that the "alarm on the door is to alert staff that someone is entering his room and then someone is to go down and investigate. Or will tell staff that he is coming out of the room". During the course of inspection on December 21, 2012, an alarm was observed on the door of resident #001. The kardex and the care plan in place at the time of the inspection, did not include the use of a sensor alarm on resident #001's door.

The written plan of care, for resident #001, did not include the use of a sensor alarm on the door, and therefore did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Two Critical Incident reports were submitted to the Ministry of Health and Long-Term Care (MOHLTC) in November 2012, outlining two separate altercation incidents between resident #001 and resident #002. In both Critical Incident reports, resident #002 had wandered and entered the room of resident #001, which resulted in an altercation. Inspector reviewed the health care record, specifically the care plan and kardex, for resident #002. The care plan relating to behaviours, included the intervention of "allow (resident #002) to wander on Resident Home Area". The care plan did not address resident #002 wandering into resident #001's room and the potential for an altercation to ensue and therefore did not set out clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 that ensures there is a written plan of care for resident #001 and resident #002 that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 14th day of March, 2013

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

Lauren Lenhardt #196.