

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 Toronto Service Area Office 5700 Yonge Street 5th Floor TORONTO ON M2M 4K5 Telephone: (416) 325-9660 Facsimile: (416) 327-4486 Bureau régional de services de Toronto 5700 rue Yonge 5e étage TORONTO ON M2M 4K5 Téléphone: (416) 325-9660 Télécopieur: (416) 327-4486

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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

Jul 30, 2015

2015_252513_0011

T-2335-15

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

MAIN STREET TERRACE 77 MAIN STREET TORONTO ON M4E 2V6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs JUDITH HART (513)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): June 2, 22, 23, and 24, 2015.

The following inspections were conducted concurrently: T-1206-14, T-1367-14, T-1471-14, and T-T-2237.

During the course of the inspection, the inspector(s) spoke with residents, personal service workers (PSWs), registered nursing staff, dietary aid, dietary manager, cook, Registered Dietitian, Director of Care, and Executive Director.

During the course of the inspection, reviewed the resident's health record, staffing schedules/assignments and dining rotation schedule.

The following Inspection Protocols were used during this inspection: Dignity, Choice and Privacy Food Quality Nutrition and Hydration

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)



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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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

- s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
- 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants:



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1. The licensee has failed to ensure to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Interview with the complainant, resident #001, revealed that he/she was addressed in an identified manner and other residents were addressed in this manner. He/she informed staff that he/she did not want to be addressed in this manner. This resident reported that he/she heard staff call other residents in this manner primarily during meals in a specified dining room, "3-4 days per week, and 12 times on some days during the meals."

Interviews with resident #002, resident #003, resident #004, and resident #005, revealed that they had observed residents being addressed in this manner. Resident #002 had been addressed in this manner and did not mind being addressed in this manner. Resident #005 stated that he would not like staff to address him in this manner.

Interviews with registered staff #103 and the Executive Director revealed that residents were sometimes addressed in this manner by personal support worker staff.

Interview with the Director of Care confirmed that addressing residents in this manner did not promote the resident's right to be treated with respect and in a way that fully recognized their individuality and respected their dignity. [s. 3. (1) 1.]

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 fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.



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Issued on this 31st day of July, 2015

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

Original report signed by the inspector.