



**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
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**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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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 2, 2014	2014_257518_0013	L-000236-14	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

ROSE GARDEN VILLA
350 DOUGALL AVENUE, WINDSOR, ON, N9A-4P4

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

ALISON FALKINGHAM (518)

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): March 25, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care.

During the course of the inspection, the inspector(s) reviewed the indicated residents complete clinical record and Policies and Procedures regarding Fall Prevention and Readmission from Hospital

**The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition**



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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

- s. 8. (1) 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 applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
 - (b) is complied with. O. Reg. 79/10, s. 8 (1).**



Findings/Faits saillants :

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place:

(b) is complied with O. Reg. 79/10, s. 8 (1)

Findings:

1. The resident had a fall.

A head injury routine was completed and documented however a fall risk assessment and a head to toe assessment were not completed post fall.

Review of the homes Policies and Procedures reveal:

Falls Prevention Program Policy RCS G-40 indicates that a fall risk assessment and a head to toe assessment must be completed post fall.

The Director of Nursing confirms these assessments were not completed and that it is her expectation that these policies be followed.

2. The resident had a fall and was transported to the hospital for an assessment. The resident returned from the hospital and the readmission checklist was not completed. This checklist would have included a head to toe assessment, fall risk assessment, SALT assessment or pain assessment was completed.

Review of the homes Policies and Procedures reveal:

Readmission from Hospital Policy RCS B-15 indicates that on any return from hospital a readmission checklist must be completed including a head to toe assessment, fall risk assessment, SALT assessment and pain assessment.

The Director of Nursing confirms the readmission checklist was not completed and that it is her expectation that these policies be followed. [s. 8. (1)]



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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 plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the act; and is complied with. O. Reg. 79/10, s. 8(1)(b), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :



The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49(2)

1. The resident fell in their room as documented in the progress notes however no post fall assessment was completed.
2. The resident fell in their room and was transported to the hospital for assessment. This resident returned from hospital and no post fall assessment was completed.
3. The resident fell in their room and was transported to hospital for assessment.

Review of the homes Policies and Procedures reveal:

Falls Prevention Program Policy RCS G-40 indicates that a fall risk assessment and a head to toe assessment be completed after a fall.

Readmission from Hospital Checklist RCS B-15 indicates that a readmission checklist which includes a fall risk assessment and a head to toe assessment be completed upon any return from hospital.

The Director of Care confirms that these assessments were not completed and it is her expectation that fall risk assessments and head to toe assessments be completed after a fall. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O.Reg. 79/10, s. 49(2), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements



Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that any actions taken with respect to a resident under the program, including assessments, reassessments, interventions and the residents responses to interventions are documented. O. Reg. 79/10, s. 30(2)

1. The resident fell and was transported to the hospital for assessment. The resident returned from hospital and there was no documentation of a Return from Hospital checklist being completed which would have included a fall risk assessment, a head to toe assessment, SALT assessment and a pain assessment.

Review of the homes Policies and Procedures reveal:

Readmission from Hospital RCS B-15 indicates that upon any return from the hospital a readmission checklist which includes a fall risk assessment, a head to toe assessment, SALT and pain assessment be completed and documented.

Director of Care confirms that these assessment were not completed or documented and it is her expectation these policies would be followed and that documentation would appear in the electronic chart , progress notes and the care plan would have been updated. [s. 30. (2)]



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Issued on this 20th day of May, 2014

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