



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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

London Service Area Office 291 King Street, 4th Floor LONDON, ON, N6B-1R8

Bureau régional de services de London 291, rue King, 4ième étage LONDON, ON, N6B-1R8

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 19, 21, 28, Nov 7, 2011; 2011_022190_0035; Critical Incident

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 SANDRA FYSH (190)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Practical Nurse and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the clinical record of one resident, observed the room and common areas for that resident and observed lunch service on one unit.

The following Inspection Protocols were used during this inspection:

- Dining Observation
Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



**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
prévues le Loi de 2007 les
foyers de soins de longue**

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. 73. Dining and snack service
Specifically failed to comply with the following subsections:

- s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
 4. Monitoring of all residents during meals.
 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
 6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
 7. Sufficient time for every resident to eat at his or her own pace.
 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Therapeutic diet lists or likes/dislikes lists were not in use during the meal, nor were show plates used for residents to choose their meal. The Personal Support Workers confirmed that diet lists and show plates were not used.
2. Inconsistent use of measurement for plating food using scoops was observed during the meal.
3. Sufficient time was not provided for residents to eat at their own pace.

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 with implementing a process to ensure that staff assisting residents are aware of the residents' diets, special needs and preferences and that the process is followed at each meal, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program



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
prévus le Loi de 2007 les
foyers de soins de longue

Specifically failed to comply with the following subsections:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Soup is served prior to the steam cart arriving on the unit. The soup was observed sitting in the hallway on a cart without a lid and after the steam cart had left the unit, soup was served to a resident in the dining room.
2. Dietary aides were observed plating sandwiches with their fingers and wiping on a cleaning cloth. No handwashing or hand sanitizing was observed during the serving of the meal.

Issued on this 7th day of November, 2011

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

A handwritten signature in cursive script, appearing to read "Andrew Tyska".