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
Jan 13, 2014	2013_256517_0004	L-000955-13	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

PATRICIA VENTURA (517)

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): December 19, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, one Registered Practical Nurse, two Personal Support Workers, one resident and the Staff Educator.

During the course of the inspection, the inspector(s) observed one resident, reviewed the resident's health care record, staff education records related to falls prevention and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Minimizing of Restraining
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified by the plan as evidenced by:

The resident's progress notes indicated that on dates throughout November and December 2013 the wheelchair was not used for mobility as indicated in the plan of care.

The plan of care indicated the resident used a wheelchair for mobility. The Director of Care confirmed the resident used a wheelchair for mobility. The Physiotherapist confirmed to staff that the resident used a wheelchair for mobility. [s. 6. (4) (a)]

2. The plan of care indicated the resident was to have a chair alarm on while sitting on the wheelchair to prevent falls.

The inspector observed the resident sitting on the wheelchair with no chair alarm on. The staff confirmed they were not applying a chair alarm to the resident since return from the hospital. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The inspector observed the resident sitting on the wheelchair across from the nurse's desk with the seatbelt not applied. During interviews staff stated the resident should have the wheelchair seatbelt applied and proceeded to apply the seatbelt to the resident.

The resident had a physician order and a Substitute Decision Maker consent signed for Tilt Wheelchair and Front-Closing Seatbelt to be used as restraints while sitting on the wheelchair. [s. 110. (2) 1.]

Issued on this 13th day of January, 2014

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

PATRICIA VENTURA