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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2015	2015_362138_0004	O-001003-14	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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 29, 2015.

The inspector also conducted a job shadowing activity with an employee of the Ministry of Health and Long Term Care during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Personal Support Workers (PSWs), Registered Practical Nurses (RPN), and Residents. Other activities conducted on the inspection included a review of a resident's health care record, a review of the call bell wait times report, verification of the call bell system, observation of staff to resident interactions, observation of a resident room as well as the physical environment of a resident home area, a review of the home's complaint log, and a tour to observe for the posting of the home's complaint process.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with section 6.(10)(b) of the Act in that the licensee failed to ensure that the resident is reassessed and the plan of care reviewed at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #002's health care record was reviewed by the inspector in conjunction with the home area's RPN. It was noted that Resident #002 was diagnosed with a specific infection in early September 2014 and again in December 2014, and was treated with antibiotics both times. The current plan of care for Resident #002, as defined by the home, was reviewed by the inspector and it was noted that there was no information relating to the recent reoccurring infections as well as a lack of corresponding goals and interventions. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 101.(2) of the regulation in that the home failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint along with other specifics as outlined in subsection 101. (2) of the regulation.

Resident #002's family member reported that an important personal item of Resident #002's has gone missing twice in the last several months. The family member stated that s/he reported this to the home but that s/he has not received a response.

The inspector spoke with the home's Executive Director regarding Resident #002's personal item. The Executive Director stated that she recalled that the resident's family member had brought forward a concern that the item had gone missing but could not recall the outcome of the concern or if she had made a response to the resident's family member. The inspector requested to see the home's complaint log. The complaint log had been provided by the Executive Director and it was noted that the complaint log did not outline the concern brought forward by the resident's family member regarding the loss of Resident #002's personal item. [s. 101. (2)]

Issued on this 6th day of February, 2015

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

Original report signed by the inspector.