



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 prévue le Loi de 2007 les foyers de soins de longue

**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

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Public Copy/Copie du public

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|-----------------------------------|---------------------------------------|
| Oct 11, 12, 13, Nov 28, 29, Dec 5, 6, 2011; Jan 9, 2012 | 2011_053122_0017 | 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

ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

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

ROSE-MARIE FARWELL (122)

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, Director of Care, 3 Registered staff, 2 Personal Support Workers, the Physiotherapy Aide, 2 residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents of the home, reviewed the respective critical incidents, reviewed the respective resident health care records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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 |



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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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.**
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
- 3. A missing or unaccounted for controlled substance.**
- 4. An injury in respect of which a person is taken to hospital.**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

Findings/Faits saillants :

1. The Inspector reviewed a resident's health care record and noted that the resident was sent to hospital on July 25, 2011. A critical incident report regarding the resident's fall with injury and transfer to hospital was submitted to the MOHLTC on July 27, 2011. The Director was not informed of the resident's injury with transfer to hospital no later than 1 business day after the occurrence of the incident.

On October 13, 2011, the Inspector interviewed the Director of Care who confirmed that the resident's injury with transfer to hospital was not reported to the Director no later than 1 business day after the occurrence of the incident.

The licensee failed to ensure that the Director was informed of an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident. [LTCHA, 2011, O. Reg. 79/10, s. 107 (3) 4].

Issued on this 9th day of January, 2012



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

A handwritten signature in cursive script, appearing to read "A. Jurek", is written within a rectangular box.