



**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**

**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**

**Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133**

**Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133**

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 15, 16, 17, Mar 21, 23, 2012	2012_051106_0006	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

MARGOT BURNS-PROUTY (106)

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 Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Contenance Care and Bowel Management

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits saillants :

1. A Critical Incident Report identifies, that on August 23, 2011, a resident expressed to an RPN allegations of verbal abuse by another staff member. The home's internal incident report regarding these allegations was submitted to management on August 24, 2011. The home did not inform the director of the alleged abuse until September 2, 2011. The licensee failed to ensure that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was reported immediately to the director. [LTCHA, 2007, S. O. 2007, c. 8, s. 24 (1) 2] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

- 1. Roller bars on wheelchairs and commodes or toilets.**
- 2. Vest or jacket restraints.**
- 3. Any device with locks that can only be released by a separate device, such as a key or magnet.**
- 4. Four point extremity restraints.**
- 5. Any device used to restrain a resident to a commode or toilet.**
- 6. Any device that cannot be immediately released by staff.**
- 7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.**

Findings/Faits saillants :

1. On August 17, 2011, a thermal blanket was used as a restraint on a resident. The blanket was wrapped around the resident's waist and hips and tied at the back of the wheelchair to prevent rising from the chair. A PSW told the inspector that another PSW tied the blanket to the wheelchair as they were concerned that the resident would sustain an injury by standing and attempting to walk post fracture. The licensee failed to ensure that the following prohibited devices that limit movement are not used in the home; sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. [O. Reg. 79/10, s. 112 (7)] (106)

Issued on this 23rd day of March, 2012

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

