



**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**

<b>Date(s) of inspection/Date(s) de l'inspection</b>	<b>Inspection No/ No de l'inspection</b>	<b>Type of Inspection/Genre d'inspection</b>
Aug 13, 14, 16, 17, Sep 24, 2012	2012_104196_0024	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**

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

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

**LAUREN TENHUNEN (196)**

**Inspection Summary/Résumé de l'inspection**

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

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents**

**During the course of the inspection, the inspector(s) conducted a tour of all resident home areas and observed the provision of care and services to residents**

**Ministry of Health and Long-Term Care (MOHLTC) Log#S-000404-12**

**The following Inspection Protocols were used during this inspection:**

**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**



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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. 89. Laundry service**

**Specifically failed to comply with the following subsections:**

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**

- (a) procedures are developed and implemented to ensure that,**
  - (i) residents' linens are changed at least once a week and more often as needed,**
  - (ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
  - (iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
  - (iv) there is a process to report and locate residents' lost clothing and personal items;**
- (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;**
- (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and**
- (d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. On August 14, 2012, the inspector observed a blue incontinent pad and a pillow case soiled with splatters of blood on a resident's bed which had been made. This same resident's bed was observed on August 16, 2012 to have the same soiled pillow case in place. The resident's pillow case remained unchanged for two days, despite having blood splatters on it.

The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, (i) residents' linens are changed at least once a week and more often as needed [O.Reg.79/10,s.89.(1)(a)(i).]

Issued on this 24th day of September, 2012



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

*[Handwritten signature]* #196.