



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**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  
Direction de l'amélioration de la  
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## Public Copy/Copie du public

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| <b>Report Date(s) /<br/>Date(s) du apport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|---|---|--------------------------------|--|
| Dec 29, 2014                                  | 2014_262523_0043                              | 009663-14                      | Complaint  |

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### **Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.  
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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### **Long-Term Care Home/Foyer de soins de longue durée**

Berkshire Care Centre  
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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

ALI NASSER (523), MELANIE NORTHEY (563)

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## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): December 22, 2014**

**During the course of the inspection, the inspector(s) spoke with the Director of Nursing and Personal Care, RAI Coordinator, Activity Coordinator Restorative Care, Physiotherapist, Physiotherapy Aide, Registered Staff, Personal Support Worker, two Family members and three residents.**

**The following Inspection Protocols were used during this inspection:  
Dignity, Choice and Privacy  
Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**

**3 WN(s)**

**3 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

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

|   |  |
|---|--|
| <p>Legend</p> <p>WN – Written Notification<br/>VPC – Voluntary Plan of Correction<br/>DR – Director Referral<br/>CO – Compliance Order<br/>WAO – Work and Activity Order</p>  | <p>Legendé</p> <p>WN – Avis écrit<br/>VPC – Plan de redressement volontaire<br/>DR – Aiguillage au directeur<br/>CO – Ordre de conformité<br/>WAO – Ordres : travaux et activités</p>  |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**
**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, as evidenced by:

On [REDACTED] inspector was at a nursing station by the Dining room, a PSW was at the nursing station desk signing another resident out and 2 other residents were in close distance when a resident in the dining room started coughing [REDACTED]. The PSW talked to the resident signing out [REDACTED]

Director of Nursing and Personal Care and PSW confirmed in an interview that the home's expectations is that the residents be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**



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

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
  - (b) is on at all times; O. Reg. 79/10, s. 17 (1).**
  - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
  - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
  - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
  - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
  - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, as evidenced by:

December 22, 2014 at 1035 am, an observation in the hallway by the elevators revealed that there is a couch and a coffee table set up for residents and families to use. There was no communication and call system that was noted in that area, it was also noted that the area is not visible to the nursing station and hidden away from the hallway.

This was confirmed by the Director of Nursing.

The Director of Nursing confirmed in an interview that the home's expectations is to have a communication and call system available in every area accessible by residents and that the couch will be removed for now as it is a safety risk for residents and families. [s.

17. (1) (e)]



***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

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

**s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:**

- 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).**
- 2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).**
- 3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).**
- 4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).**
- 5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).**
- 6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).**
- 7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).**
- 8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).**

**Findings/Faits saillants :**



1. The Licensee has failed to ensure that the 24 hours admission care plan includes, at a minimum, the following with respect to the resident's Skin condition, including interventions; and Diet orders, including food texture, fluid consistencies and food restrictions, as evidenced by:

On December 22, 2014 at 1200, a review of an identified resident's initial care plan revealed that the plan did not reflect the correct information about the resident specifically related to skin condition including; and diet orders, including food texture, fluid consistencies and food restrictions.

This was confirmed by Director of Nursing and the RAI Coordinator.

They both confirmed in an interview that the initial plan of care did not include the information and care required to resident in regards to his skin condition or care and nutritional needs or status. [s. 24. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 24 hours admission care plan includes, at a minimum, the following with respect to the resident's Skin condition, including interventions; and Diet orders, including food texture, fluid consistencies and food restrictions, to be implemented voluntarily.***

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Issued on this 29th day of December, 2014

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

Original report signed by the inspector.