



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

**Rapport d'inspection
prévue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
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			<input type="checkbox"/> Licensee Copy/Copie du Titulaire <input checked="" type="checkbox"/> Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection	
January 11, 2011	2011_115_2541_11Jan130824	L-01851 Critical Incident	
Licensee/Titulaire Revera Long Term Care Inc., 55 Standish Court, 8 th Floor, Mississauga, ON., L5R 4B2			
Long-Term Care Home/Foyer de soins de longue durée Rose Garden Villa, 350 Dougall Ave., Windsor, ON., N9A 4B2			
Name of Inspector(s)/Nom de l'inspecteur(s) Terri Daly #115			
Inspection Summary/Sommaire d'inspection			
The purpose of this inspection was to conduct a critical incident inspection.			
During the course of the inspection, the inspector spoke with: the Executive Director, DOC, 1 RPN, and 1 PSW			
During the course of the inspection, the inspector: toured the resident room, met resident, and reviewed clinical records of 1 resident			
The following Inspection Protocols were used in part or in whole during this inspection: Personal Support Services Safe & Secure Home Inspection			
<input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken:			
2 WN 2 VPC			



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NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Référant envoyé

CO – Compliance Order/Ordre de conformité

WAO – Work and Activity Order/Ordre: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

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.)

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.)

WN #1: The Licensee has failed to comply with O.Reg. 79/10, s.26(3)18

A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Special treatments and interventions.

Findings:

- One resident found to be prescribed an anticoagulant, however interventions related to anticoagulant therapy are not addressed on the plan of care.

Inspector ID #: 115

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 the plan of care reflects special treatments and interventions with respect to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with [O.Reg. 79/10, s.26(3)3]

A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Communication abilities, including hearing and language.

Findings:

- During a resident interview, resident found to be unable to respond to simple questions, instead just held my hand and smiled. Staff indicate that this resident's communication is limited. The RAP for the resident indicates concerns related to communication, language barrier, perhaps related to the diagnosis. The plan of care discusses interventions related to verbal communication which contradicts the RAP and the staff's description of the resident's communication.

Inspector ID #: 115

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 the appropriate assessment is conducted with respect to the resident's communication abilities and language, to be implemented voluntarily.

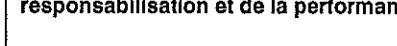


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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. 
Title:	Date:
	Date of Report: (if different from date(s) of inspection).
	January 21, 2011