



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

**Rapport d'inspection  
prévues 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

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

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<b>Date(s) of inspection/Date de l'inspection</b> September 9, 2010	<b>Inspection No/ d'inspection</b> 2010-115-2541-09Sep133022	<b>Type of Inspection/Genre d'inspection</b> Critical Incident L-00916
<b>Licensee/Titulaire</b> Revera Long Term Care Inc., 55 Standish Court, 8 <sup>th</sup> Floor, Mississauga, ON., L5R 4B2		
<b>Long-Term Care Home/Foyer de soins de longue durée</b> Versa Care Windsor Place, 350 Dougall Avenue, Windsor, ON N9A 4P4		
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b> Terri Daly #115 Sandra Fysh #190		
<b>Inspection Summary/Sommaire d'inspection</b>		
<p>The purpose of this inspection was to conduct a critical incident inspection.</p> <p>During the course of the inspection, the inspector(s) spoke with: Administrator, Director of Care, Assistant Director of Care, 1 RPN, and 1 PSW.</p> <p>During the course of the inspection, the inspector(s): reviewed the CI report related to the incident, reviewed clinical record of resident.</p> <p>The following Inspection Protocols were used in part or in whole during this inspection: Dignity, Choice and Privacy Inspection Protocol</p> <p><input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken: 4 WN</p>		

**NON- COMPLIANCE / (Non-respectés)**
**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit  
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire  
**DR** – Director Referral/Régisseur envoyé  
**CO** – Compliance Order/Ordres de conformité  
**WAO** – Work and Activity Order/Ordres: travaux et activités

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

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 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-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 LTCHA, S.O. 2007, c.8, s.6(1)(c)  
 Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,  
 (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

**Findings:**

The plan of care is generic and does not provide clear individualized directions for staff related to the resident's bladder continence care and history.

**Inspector ID #:** 115 & 190

**WN #2:** The Licensee has failed to comply with LTCHA, S.O. 2007, c.8, s.6(10)(c)  
 The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,  
 (c) care set out in the plan has not been effective. 2007, c. 8., s. 6 (10).

**Findings:**

The plan of care has not been revised to reflect recent diagnosis related to a recent hospitalization.

**Inspector ID #:** 115 & 190

**WN #3:** The Licensee has failed to comply with LTCHA, S.O. 2007, c.8, s.6(2)  
 The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2)

**Findings:**

The plan of care does not reflect the residents' needs related to a diagnosis related to a recent hospitalization.

**Inspector ID #:** 115 & 190



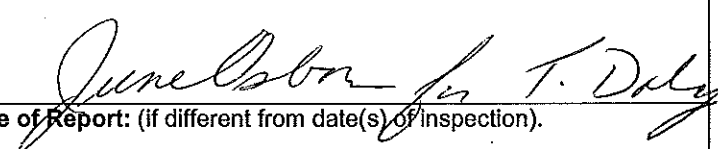
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<b>WN #4:</b> The Licensee has failed to comply with O.Reg. 79/10, s.231.(b) Every licensee of a long-term care home shall ensure that, (b) the resident's written record is kept up to date at all times.	
<b>Findings:</b> Progress notes were not up to date related to an incident and follow up in regard to the resident's status.	
<b>Inspector ID #:</b>	115 & 190

<b>Signature of Licensee or Representative of Licensee</b> Signature du Titulaire du représentant désigné		<b>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.</b>	
<b>Title:</b>	<b>Date:</b>		
		<b>Date of Report:</b> (if different from date(s) of inspection). October 1, 2010	