Ontario

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 conformité

London Service Area Office
291 King Street, 4th Floor
London ON N6B 1R8

Telephone: 519-675-7680
Facsimile: 519-675-7685

Bureau régional de services de London
291, rue King, 4iém étage
London ON N6B 1R8

Téléphone: 519-675-7680
Télécopieur: 519-675-7685

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 9, 2010	2010-115-2541-09Sep133022	Critical Incident L-00916

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, ON., L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Versa Care Windsor Place, 350 Dougall Avenue, Windsor, ON N9A 4P4

Name of Inspector(s)/Nom de l'inspecteur(s)
Terri Daly #115
Sandra Fysh #190

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(s) spoke with: Administrator, Director of Care, Assistant Director of Care, 1 RPN, and 1 PSW.

During the course of the inspection, the inspector(s): reviewed the CI report related to the incident, reviewed clinical record of resident.

The following Inspection Protocols were used in part or in whole during this inspection:
Dignity, Choice and Privacy Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN

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

WN #4: The Licensee has failed to comply with 0.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.	
Findings: Progress notes were not up to date related to an incident and follow up in regard to the resident's status.	
Inspector ID #:	115 & 190

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). October 1, 2010