Ontario

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

Rapport d'inspection prevue 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

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 23, 24, 2010	2010-144-2541-23Sept104952	**CI Follow-Up** **L-01087** **CI-2541-000058-10**

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Ave., Windsor, ON N9A 4B2

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

Name of Inspector(s)/Nom de l'inspecteur(s)

Carolee Milliner (#144)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident follow-up inspection related to family concerns about inadequate care of a resident..

During the course of the inspection, the inspector spoke with the Administrator, Director of Care, Food Service Supervisor & RAI-MDS Coordinator.

During the course of the inspection, the inspector reviewed one resident clinical record & two home Nutritional Care & Meal Service Policies.

The following Inspection Protocols were used in part or in whole during this inspection:
Support & Personal Care
Skin & Wound
Nutrition

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

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

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

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'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, S.O. 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, clear directions to staff and others who provide direct care to the resident.

Findings:

1. The written plan of care for one resident does not include clear nutritional directions for staff to promote wound healing & to manage symptoms related to other identified diagnosis.

Further Inspector Findings:
VPC-pursuant LTCHA, 2007, S.O. c.8,s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to be implemented voluntarily.
The voluntary plan of correction should relate to the resident's written plan of care providing clear directions to staff that provide direct care to the resident.

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WN #2: 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, the resident's written record is kept up to date at all times.

Findings:
.1. One resident's written record does not include documentation related to PSW observation records & nutritional intake for the period identified.

Further Inspector Findings:
VPC-pursuant LTCHA, 2007, S.O. c.8,s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to be implemented voluntarily.
The voluntary plan of correction should relate to the resident's written record being kept up to date.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, s.24(9)(a).
The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when, the resident's care needs change.

Findings:
1. The physician changed the frequency of one resident's narcotic analgesic. A pain assessment was not completed when the resident's care needs changed related to pain.

Further Inspector Findings:
VPC-pursuant LTCHA, 2007, S.O. c.8,s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to be implemented voluntarily.
The voluntary plan of correction should relate to reassessment when the resident's care needs change.

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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).** October 6, 2010