



**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
performance et de la conformité**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 17, 2014	2014_267528_0009	H-000332- 13	Complaint

Licensee/Titulaire de permis

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

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

WEST OAK VILLAGE
2370 THIRD LINE, OAKVILLE, ON, L6M-4E2

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection



**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**

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

**This inspection was conducted on the following date(s): February 26 and 27,
2014**

**This inspection was done concurrently with critical incident system inspection
#2014_267528_0008 / H-000360-13**

**During the course of the inspection, the inspector(s) spoke with the
Administrator, Director of Care (DOC), Assistant Director of Care (ADOC),
Resident Services Coordinator (RSC), Registered Practical Nurses (RPN's),
Personal Support Workers (PSW's), residents and families.**

**During the course of the inspection, the inspector(s) observed the provision of
care, reviewed relevant clinical health records, policies and procedures, and
complaints log related to Log# H-000332-13.**

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints



Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).

(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a documented record is kept in the home that included:

(a) the nature of each verbal or written complaint

(b) the date the complaint was received

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required

(d) the final resolution, if any

(e) every date on which any response was provided to the complainant and a description of the response, and

(f) any response made by the complainant. O. Reg. s. 101 (2)

A. The Power of Attorney (POA) for resident #001 reported to the inspector that resident care concerns/complaints were expressed to staff in the home in June 2013 and February 2014. Review of the home's documented complaints log from January 2013 to February 26, 2014 showed no documented care concerns/complaints from the POA of resident #001. Administrative staff confirmed that they were aware of the POA's care concerns/complaints. The Resident Services Coordinator (RSC) confirmed she was aware of care concerns in the "summer of 2013", which were not included in the complaint log. The ADOC confirmed he addressed care concerns/complaints in February 2014, which were not included in the complaint log. [s. 101. (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 a documented record is kept in the home that includes:

- (a) the nature of each verbal or written complaint***
- (b) the date the complaint was received***
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required***
- (d) the final resolution, if any***
- (e) every date on which any response was provided to the complainant and a description of the response, and***
- (f) any response made by the complainant., to be implemented voluntarily.***

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :



1. The licensee did not ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care. LTCHA s. 6 (5).

A. In August 2013, physician orders were received to discontinue a medication for resident #001. Additional physician orders were noted in August 2013 for ongoing blood work and investigative tests. The POA was not notified of medication change or ongoing testing until September 2013, when a message was left by the physician.

B. In January 2014, resident #001 had a confrontation with other residents and, as a result, was placed on one to one safety monitoring for approximately five days. The resident had two identified POA's. The first POA was notified at that time. The second POA indicated she was not made aware of the incident until visiting the following week. Review of the plan of care included a letter from October 2013, indicating that the second POA was to be called for any concerns. A second letter from October 2013, signed by both POA's, stated that the second POA was to be the primary contact for the resident. Review of progress notes showed the first POA was updated on the day of the incident. The Director of Care (DOC) confirmed that the second POA was not notified of the incident by the staff in the home. [s. 6. (5)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

- s. 27. (1) Every licensee of a long-term care home shall ensure that,**
- (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**
 - (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**
 - (c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**



Findings/Faits saillants :

1. The licensee did not ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission. O. Reg. s. 27 (1) (a)

A. Resident #001 was admitted to the home on in February 2013. The six week interdisciplinary care conference was held in June 2013. The RSC confirmed that the care conference was not held within six weeks of admission. [s. 27. (1) (a)]

Issued on this 1st day of April, 2014

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