



**Ministry of Health and
Long-Term Care**

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

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2016	2016_531518_0050	001907-16	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

RIVERSIDE PLACE
3181 Meadowbrook Lane WINDSOR ON N8T 0A4

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

ALISON FALKINGHAM (518)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): November 2, 2016

This inspection was conducted as a result of a complaint alleging improper resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Registered Nurses, one Registered Practical Nurse, three Personal Support Workers and one housekeeper. The Inspector also reviewed three resident clinical records, the home's policies, observed general staff to resident interactions and housekeeper practices.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management
Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A resident was admitted to the home with issues related to incontinence.

An assessment indicated the resident required extensive assistance regarding these issues.

The most recent care plan indicated that the resident used a medical device with extensive assistance and was placed on a nursing rehabilitation program at the resident's request.

Three registered staff members stated there were no specific assessments related to these issues in the computerized or paper clinical record.

A resident was admitted with issues related to incontinence.

An assessment indicated this resident required extensive assistance with these issues.

The most recent care plan for this resident indicated the resident was on a schedule related to these issues.

Three registered staff members stated there were no specific assessments related to this issue completed in the computerized or paper clinical record.

The DOC verified that the expectation was a resident who had specific issues related to incontinence should receive an assessment that included identification of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [s. 51. (2) (a)]



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Issued on this 5th day of December, 2016

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

Original report signed by the inspector.