



**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, 4th étage
London ON N6B 1R8

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

			<input type="checkbox"/> Licensee Copy/Copie du Titulaire	<input checked="" type="checkbox"/> Public Copy/Copie Public
Date of inspection/Date de l'inspection April 20, 2011	Inspection No/ d'inspection 2011_144_2972_20Apr100350	Type of Inspection/Genre d'Inspection L-000599-11 Complaint		
Licensee/Titulaire Revera Long Term Care Inc., 55 Standish Court, 8 th 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/Nom de l'inspecteur Carolee Milliner (#144)				
Inspection Summary/Sommaire d'inspection				
The purpose of this inspection was to conduct a complaint investigation related to a resident death.				
During the course of the inspection, the inspector spoke with the Administrator & Director of care.				
During the course of the inspection, the inspector reviewed one resident clinical record & the home policies related to resident weights & death of a resident.				
The following Inspection Protocols were used in part or in whole during this inspection: None.				
<input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken:				
3 WN 1 VPC				



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NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Référencement envoyé

CO – Compliance Order/Ordre de conformité

WAO – Work and Activity Order/Ordre: 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 constitue 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 O.Reg.79/10,s.24(3)(b).

The licensee shall ensure that the care plan sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. The care plan for one resident, on review, does not provide clear directions to staff & others who provide direct care to the resident; goals & interventions related to end of life care have not been included in the written plan of care.

Inspector ID #: 144

WN #2: The Licensee has failed to comply with O.Reg.79/10,s.24(8).

The licensee shall ensure that the provision and outcomes of the care set out in the care plan are documented.

Findings:

1. Review of the clinical record for one resident confirmed there is no documentation related to the resident's deteriorating health status on 4/6 shifts.

Inspector ID #: 144

WN #3: The Licensee has failed to comply with O.Reg.79/10,s.8(1)(b)

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with.



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Findings:

Review of the clinical record for one resident & interview with the Director of Care confirmed:

1. A referral was not made to the Registered Dietician in response to the resident's weight loss between as required in the home Weight Policy.
2. A physician's order was not obtained for release of the resident's body upon death of the resident as directed in the home Admission, Discharge, Transfer & Death Policy.

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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 related to referral to the Registered Dietician, to be implemented voluntarily.

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 of Report: April 29, 2011