Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 19, 23, 24, 30, Nov 1, 2012	2012_128138_0040	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

STONERIDGE MANOR
256 HIGH STREET, CARLETON PLACE, ON, K7C-1X1

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Office Manager, RAI Coordinator, Regional Manager of Clinical Services, a registered nurse, several personal support workers (PSW) from day and evening shifts, and residents.
The inspection occurred on site Oct 23 and 24, 2012

During the course of the inspection, the inspector(s) observed resident care, observed a meal service, reviewed resident health records, and reviewed an internal Client Response Form.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 s. 6. (7) in that the care set out in the plan of care was not provided to a resident as specified in the plan.
Resident #1's care plan provided by the RAI Coordinator stated that the resident is to be toileted before and after meals. Observation of Resident #1 during the inspection demonstrated that the resident was not toileted after a lunch meal but instead toileted in the afternoon by the evening shift. The home's RAI Coordinator stated that the expectation in the home was that residents who required toileting after meals be toileted by the day staff prior to the end of the shift at 2:00pm. Discussion with staff on the evening shift confirmed that Resident #1 is in need of being toileted as soon as possible at the start of the evening shift. The same staff confirmed that it would be beneficial to the resident to have him/her toileted after lunch rather than the start of the evening shift to prevent leakage of his/her continence products.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 33 (1) in that each resident of the home was not bathed, at a minimum, twice a week by the method of his or her choice.
Resident #1 and Resident #2 did not receive their baths, normally scheduled on weekends, on a weekend in September 2012. The home's Office Manager confirmed that the home was short staff which was a factor in these two residents not receiving their baths.

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Issued on this 1st day of November, 2012

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