



**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**

**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, 4^{ième} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670**

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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
Apr 29, 2013	2013_049143_0021	O-000282- 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

WINBOURNE PARK

1020 Westney Road North, AJAX, ON, L1T-4K6

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 15th-17th, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Nursing, Registered Practical Nurses, residents and family members.

During the course of the inspection, the inspector(s) reviewed policies and procedures, reviewed resident health care records and observed resident care and services.

The following Inspection Protocols were used during this inspection:



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Continence Care and Bowel Management

Hospitalization and Death

Medication

Nutrition and Hydration

Personal Support Services

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 30. General requirements



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Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :



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1. On a specified date resident # 1 was admitted as a short stay resident. A review of the Revera Long Term Care Services Manual Subject Short Stay/Respite Care page 2 of 3 (LTC-A-70) procedure seven states:

The standard of care and the documentation requirements for recipients of respite care services are consistent with standards set for all Residents of Long Term Care Centres.

A review of the health care record indicated incomplete documentation as followed: The lift and transfer recorded indicated that the assessment was completed on a specified date when resident #1 was not resident of the home.

The Do not Resuscitate Confirmation Form (completed on a specified date) indicated no CPR when the Life Care Directives completed by the Power of Attorney indicated a level four transfer to Acute Care Hospital with CPR.

A review of the food and fluid tracking-Snacks indicated no PM Snack and fluid were documented.

The medication administration record on a specified date had a signature omission for a medication. The Administrator confirmed that the medication had been administered by Staff # S101.

On a specified date and time an entry in the progress notes indicated that resident #1 had complained of discomfort. No further documented assessments, reassessments, interventions and resident responses were completed for greater then twenty one hours at which time resident #1 was transferred to hospital.

Resident #2 was admitted to the home in a short stay bed for a specified period. A review of the health care record indicated that the form for tracking snacks had no documented assessments of the resident #2's nutritional intake.

Resident #3 was admitted to the home in a short stay bed for a specified period. A review of the food and fluid tracking snacks form indicated no documented assessments that a between-meal beverage was offered to the resident.

The licensee has failed to ensure that documented assessments are completed as required. [s. 30. (2)]



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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 to ensure that all residents have documented assessments, reassessments and interventions documented, to be implemented voluntarily.

Issued on this 29th day of April, 2013

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