Ontario

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
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
May 5, 2011	2011-144-2263-05May102649	L-00307 Critical Incident

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, ON., L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Banwell Gardens, 3000 Banwell Road, Tecumseh, ON., N8N 2M4

Name of Inspector(s)/Nom de l'inspecteur(s)
Carolee Milliner (#144)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to resident care & services.

During the course of the inspection, the inspector spoke with one resident, the Director of Care & one Registered Nurse.

During the course of the inspection, the inspector reviewed the critical incident report, two resident clinical records & the home Resident None-Abuse Policy.

The following Inspection Protocols were used in part or in whole during this inspection:
Responsive Behaviours

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: 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 constituer 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 LTCHA,2007,S.O.c.8,s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:
1. The written nutritional plan of care for one resident does not include feeding recommendations that resulted from swallowing assessment.
2. The quarterly nutritional assessment for one resident incorrectly identifies two diagnosis the resident does not have.

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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 ensuring the plan of care provides clear directives to staff with implementation of assessment recommendations & correct resident diagnosis, to be implemented voluntarily.

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. The plan of care for one resident directs staff to implement safety checks in response to an incident of resident to resident abuse. The clinical record does not include documentation of the outcome of the safety checks for the period of time directed.

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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.

Findings:
1. The home Resident Non-Abuse policy was not followed in response to a resident to resident abuse incident. The clinical record for one resident on review confirms nursing staff did not complete an assessment of the resident for physical injury until two days after the incident.
2. Registered personnel did not secure a Physician or Registered Dietician order for changes to one residents' diet texture on two occasions as required by the home protocol.

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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 ensuring the home Non-Resident Abuse Policy & resident diet order protocols are followed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg.79/10,s.97(1)(b)
Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:
1. Review of the clinical record for one resident confirmed the substitute decision maker was not notified of an incident of resident ~~to resident~~ abuse within 12 hours.

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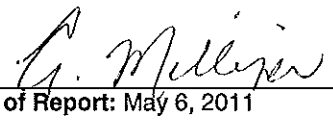
Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to notification to the substitute decision maker within 12 hours of the licensee becoming aware of an incident of abuse, 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:**	**Date of Report:** May 6, 2011