Ontario

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

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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
Jun 24, 2014	2014_349590_0007	L-000590-14	Resident Quality Inspection

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

BANWELL GARDENS
3000 BANWELL ROAD, P. O. BOX 3246, TECUMSEH, ON, N8N-2M4

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

ALICIA MARLATT (590), CAROLEE MILLINER (144), ROCHELLE SPICER (516)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 20, 21, 22, 23, 26, 27, 30 & June 2, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Resident Care, the President of the Residents Council, the Vice President of the Residents Council, the Program and Restorative Care Manager, the Maintenance/Housekeeping/Laundry Manager, an external Maintenance Employee Manager, the Food Services Manager, the Infection Control Lead, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Laundry Aide, a Housekeeping Aide, 40+ Residents and family members of Residents.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information, meeting minutes to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.

a) A resident was observed feeding themself in the dining room during the lunch meal.
b) The multiple data set (MDS) annual assessment, section V, identifies this resident as unable to feed themself.
c) One staff confirmed the resident feeds themself on an ongoing basis.
d) The written plan of care for this resident identifies the resident requires supervision only for eating. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.

a) A resident was noted to have a procedure completed recently.
b) During an interview the resident shared that they continue to have considerable discomfort.
c) Two staff confirmed the resident continues to have post procedure discomfort.
d) The resident's written plan of care does not include directives for management of the resident's ongoing mouth pain. [s. 6. (1) (c)]

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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, it's furnishings and equipment were kept clean and sanitary.

a) Housekeeping concerns were noted during stage one of the RQI in several residents rooms such as significant build up of dirt along the window sills and a bathroom sink had a build up of debris along the sink seal and caulking.
b) An Inspector and the Director of Nursing and Resident Care viewed these areas together. The Director of Nursing and Resident Care confirmed the areas listed above did not meet the homes expectations in regards to housekeeping of the home. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and good state of repair.

a) Maintenance concerns were noted during stage one of the RQI throughout the home.
b) In a resident room there was a patched area above the bathroom mirror where the wall and ceiling meet and there were scrapes on the bathroom door and wall.
c) In a resident room a strip of wall moulding that holds electrical wires was pulled away from the wall and the screws were exposed and the inside of bathroom door was chipped.
e) In a resident room there were large chips out of the bathroom door and a piece of wall moulding under the bedroom windows was pulled away from the wall and the screws were exposed.
f) In a resident room there was a large scrape along the inside of the bathroom door.
g) In a resident room there was paint chipped on the wall behind a headboard, the bathroom sink had a quarter size chip and the bathroom door frame and wall were scraped.
h) In a resident room the caulking and paint along the bathroom counter was damaged, the baseboard was pulled away from the wall beside the toilet and the bathroom door had scrapes.
i) An Inspector and the Director of Nursing and Resident Care viewed these areas together. The Director of Nursing and Resident Care confirmed the areas listed above did not meet the homes expectations in regards to ensuring the home, furnishings, and/or equipment were maintained in a safe condition and good state of repair. [s. 15. (2) (c)]

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 the home, it's furnishings and equipment were kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

a) A resident was heard calling out for help in their room as Inspector #516 was walking by.
b) Inspector #516 noted that the residents call bell was not in reach and pulled the call bell for help.
c) A Personal Support Worker, answered the call bell and confirmed that the call bell should have been within the residents reach and assisted resident. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

a) A resident has been assessed as high risk for falls and has experienced eleven falls to date in 2014.
b) The residents written plan of care provides direction for the residents call bell to be accessible at all times.
c) An inspector noted that the residents call bell was positioned behind the head board of their bed. Two unsuccessful attempts were made by the resident to reach the call bell.
d) Two staff confirmed the resident's call bell should be within reach at all times. [s. 17. (1) (a)]

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 the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that housekeeping procedures were implemented for residents.

a) From May 20, 2014 throughout the RQI review, a strong, foul, unwanted and ongoing urine odour has been noted in the home.
b) One management staff confirmed their knowledge of the ongoing odour and confirmed various initiatives have not been successful in eliminating the urine smell. [s. 87. (2) (d)]

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 housekeeping procedures are implemented for all residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

a) Inspector #516 observed an unlabeled kidney basin and a bedpan being stored side by side in a shared residents bathroom. The Director of Nursing and Resident Care confirmed that these findings did not comply with the homes established infection control practices.
b) Inspector #516 observed a shower chair in shower room 1A which has a ripped foam seat and was stained. The Director of Nursing and Resident Care viewed the seat and confirmed this posed an infection risk to residents.
c) Inspector #516 observed an unlabeled urine collection device in a residents room. The Director of Nursing and Resident Care confirmed that the urine collection device should have been labeled with a resident name per the homes established infection control practices. [s. 229. (4)]

2. The licensee has failed to ensure that residents are offered immunizations against tetanus in accordance with the publicly funded immunization schedules posted on the Ministry website.

a) Review of immunization health records revealed that residents were not offered tetanus immunizations in accordance with the publicly funded immunization schedules posted on the Ministry website.
b) The Administrator confirmed the home has not consistently offered tetanus immunizations to residents since 2010 in accordance with the publicly funded immunization schedules posted on the Ministry website.
c) The Administrator confirmed that only one resident has been offered tetanus immunization from 2010 to date. [s. 229. (10) 3.]

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 staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal

health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of a resident were fully respected and promoted specifically in regards to having his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that act.

a) An inspector observed an unattended Point Of Care kiosk with a resident screen containing personal health information open and accessible.
b) A Registered Practical Nurse confirmed the kiosk should have been locked and logged out when not being used by a staff member. [s. 3. (1)]

2. The licensee failed to ensure that every resident was afforded privacy in treatment and in caring for his or her personal needs.

a) During the lunch medication pass, a resident was observed being administered specific treatments in the corridor outside dining room B.
b) One registered staff shared that providing selected treatments in the corridor is a common practice of the home due to the residents rooms being located too far away from the dining room.
c) One management personnel confirmed the expectation is that resident treatments are to be provided in the privacy of their room and that this privacy issue has been discussed with registered personnel on more than a few occasions. [s. 3. (1) 8.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system in place was complied with.

a) Observations of resident clothing storage areas were completed by Inspector #516 with the Director Of Nursing and Resident Care present.
b) Several articles of clothing were not folded or neatly organized in one residents wardrobe.
c) The home policy for "Delivery of Personal Laundry" states, "the clothing must be placed neatly in the closets and drawers".
d) The Director Of Nursing and Resident Care confirmed that this resident is not capable of retrieving clothing from their wardrobe or managing the organization of their clothing and that the home provides this service.
e) The Director of Nursing and Resident Care confirmed this did not meet the home's policy and expectations. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

a) The homes Director of Nursing and Resident Care and Inspector #516 viewed the windows in a Residents bedroom. There are two windows in the bedroom, side by side.
b) Both windows opened greater than 15cm and one window was missing a screen.
c) This was confirmed by the Director of Nursing and Resident Care. [s. 16.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
a) Review of a Residents record revealed a significant weight change over a three week period
b) Since the recorded weight change the resident has not been re-weighed and an assessment using a multidisciplinary approach has not been completed.
c) One staff confirmed the resident was not re-weighed.
d) One Management personnel confirmed the resident should have been re-weighed, a referral made to the registered dietitian and an interdisciplinary assessment completed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101.

a) During an inspection related to missing money, it was noted that the homes Investigation Response Form Policy does not include the requirement for the home to document every date on which any response was provided to the complainant and the description of the response.
b) One Management staff confirmed that the homes policy does not include requirements for documentation of responses provided to complainants and further confirmed that the responses provided were not documented. [s. 100.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

a) A resident was noted to have a restraint in place.
b) Review of the residents clinical record revealed that the resident is not monitored while restrained at least every hour by a member of the registered nursing staff.
c) One Management staff confirmed that it is the homes expectation that residents are monitored while restrained as required by the legislation. [s. 110. (2) 3.]

Issued on this 18th day of July, 2014

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