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
	2012_179103_0017	O-001712-12	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

BAY RIDGES
900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4

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

DARLENE MURPHY (103)

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): November 19, 20, 21, 22, 23, 26, 27, 2012

During this inspection a total of six complaints were inspected with the following log numbers: #O-000267-12, #O-000648-12, #O-001294-12, #O-001712-12, #O-002272-12, #O-002343-12.

During the course of the inspection, the inspector(s) spoke with Personal support workers, Registered Nursing staff, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) did a walk through of the home, observed resident care, reviewed resident health care records and the home's policy on abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 50 (2) (b) (iv) whereby a resident exhibiting altered skin integrity was not reassessed by a member of the registered nursing staff at least weekly.

Resident #5 returned from a hospital stay. Registered nursing staff completed a head to toe assessment at that time and identified an area of impaired skin integrity.

The resident health care record was reviewed and there was no indication of weekly reassessments. The resident's wound was noted to have deteriorated and required antibiotics for the presence of infection and regular dressing changes.

2. The licensee has failed to comply with O. Reg 79/10 s. 50 (2) (b) (ii) whereby a resident exhibiting altered skin integrity did not receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

Resident #5 returned from a hospital stay. Registered nursing staff completed a head to toe assessment and identified an area of altered skin integrity. There is no further documentation to reflect the treatment or assessment of this area until approximately one month later. At that time, the documentation reflects the wound had deteriorated.

The plan of care in effect at that time was reviewed and there was no indication of pressure relieving measures or treatments being put into place upon the discovery of the altered skin integrity.

The licensee failed to provide immediate treatment and interventions to promote the healing and prevent infection of Resident #5's wound upon its discovery.

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 all residents with impaired skin integrity receive immediate treatment and interventions to promote healing and prevent infection, and are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #2: 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:
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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 3 (1) (11) (ii) whereby a resident's right to refuse any treatment, care or services was not respected.

Resident #1 had a cognitive impairment and, according to the plan of care, was known by staff to refuse care including medications, meals, and personal care. On an identified date, Resident #1 was observed by staff to have evidence of incontinence.

One staff member attempted to shower the resident who initially was accepting of the care. The resident began resisting the care at which time additional staff were asked to assist. A critical incident report was submitted and indicated it took four staff and nurse to shower the resident and put on clean clothes. The resident was physically and verbally aggressive throughout the care and attempted to punch the staff. Following this documented incident, Resident #1's family member found bruising on the resident and believed the staff used poor judgement in managing the care.

Staff failed to respect the resident's right to refuse care.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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 :

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l. The licensee has failed to comply with O. Reg 79/10 s. 33 (1) whereby residents are not being bathed at a minimum of twice weekly.

Resident #10's plan of care indicates a bath/shower is to be completed twice weekly according to the bathing schedule. The bathing documentation records were reviewed or the months of August and October, 2012. The bathing records indicated the esident was bathed as follows:
August 2, 5, 9, 12, 23, and 30. The remaining dates for this month were coded with "8" which according to the legend indicates "the activity did not occur".
October 1, 4, 11, 14, 18, 21, and 25. October 4, 11, 14 and 25 indicated a refusal of care and the remaining dates for this month were coded with "8".
Resident #9's plan of care indicates a bath/shower is to be completed twice weekly according to the bathing schedule . The bathing documentation records were eviewed for the months of September and October, 2012. The bathing record ndicated the resident was bathed as follows:
September 3, 7, 10, 17, 21, and 24. The remaining dates for this month were coded with "8".
October 1, 2, 5, 8, 15, 16, 19, 26, 31. October 5 was documented as a refusal and he remaining dates for this month were coded with "8".
Resident #3's plan of care indicates a bath/shower is to be completed twice weekly according to the bathing schedule. The bathing documentation records were eviewed for the months of August, September and October, 2012. The bathing record ndicated the resident was bathed as follows:
August 1, 8, 15, 16, 18, 22 and 29. The remaining dates for this month were coded with "8" which according to the legend indicates "the activity did not occur".
September 5, 8, 12, 16, 19, and 26. The remaining dates for this month were coded with "8".
October 2, 6, 10, 17, 20, 24, 27 and 31. The remaining dates for this month were coded with "8".

Issued on this 30th day of November, 2012

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

Darlene Murphy