Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 15, 2013	2013_225126_0009	O-000312-13,000448,000458-13	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

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

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

LINDA HARKINS (126)

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): June 18-19-20, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Registered Dietitian, the Food Service Supervisor, several Registered Nursing Staff, Several Personal Support Workers, two Former members of the Resident Council, residents and families.

During the course of the inspection, the inspector(s) reviewed several health care records, review the Resident's Council Minutes, observed care and services provided to residents.

During the course of this inspections, three complaints inspections were conducted.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Family Council

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

Specifically failed to comply with the following:

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.O. 2007, c.8, s.6.(7) whereby the licensee did not ensure the care set out as specified in the plan of care was provided to Resident #3.

Resident #3 was prescribed a food supplement drink three times a day. On a specified week end in June 2013, Resident #3 did not receives the prescribed food supplement.
The progress notes of a specified day in June 2013,documents that Resident#3 did not receive scheduled food supplement this weekend, as none was available on the unit.
The following Monday of that specific week end, the full time day, Registered Practical Nurse was able to obtain the food supplement drink from the kitchen and resume giving it as prescribed.

The food supplement drink was not administered to Resident #3 as per orders. [s. 6. (7)]

WN #2: 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 failed to comply with O. Reg 79/10 s.17(a) whereby the resident call bell was not within reach on a specified day in March 2013.

On a specified morning of March 2013, Resident #1 called a family member and stated that the evening staff hid the call bell and that he/she had to call the home using his/her own phone to get assistance with care on two occasions that evening.

In the progress note of the specified day in March 2013,Registered Practical Nurse (RPN) S#101 documented that later that evening he/she received two pages to pick up a telephone call, both pages were from Resident #1 calling for writer to come to resident's room.

On June 19, 2013,Inspector #126, interviewed RPN S#101 and Health Care Aid S#102. Both staff indicated that Resident #1 was unstable and required a two person transfer lift at that time and that made him/her upset. S#102, indicated that Resident #1 requested to go to the bathroom frequently and sometimes was toileted without any result. They both indicated that the Resident call bell was within reach but was under the blanket and that was probably the reason why the Resident did not have the call bell within reach because he/she could not see it.

On June 18, 2013, Inspector #126 interviewed full time day RPN S#100. She indicated that he/she talked to Resident #1 the following morning of the incident and Resident #1 told him/her that the staff hid the call bell and that had to use his/her own phone to get assistance from staff. S#100 indicated that Resident #1 was alert and oriented.

Telephone discussion held with Resident #1's family member, who indicated that he/she received a telephone call from the Resident the morning following the incident and told them that staff hid the call bell and that had to use his/her own phone in his/her room to call the nursing home so somebody could help him/her. The telephone calls to the home was confirmed by RPN #101 in the late entry progress notes of a specific date in March 2013.

The call point detailed activity report by location for a specific room was reviewed on June 19, 2013 by Inspector #126, it is noted that Resident #1 used her call bell system on a specific date in March 2013 in the evening and did not use it until the next shift early morning. The call bell was not used for a period of approximately over

7 hours.

The call bell was not within reach of Resident #1 the evening of a specified date in March 2013. [s. 17. (1) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O.2007 c.8 S.65. (a) whereby the home did interfere with the operation of the Family Council by removing the Family Council minutes of September 2012 from the bulletin board.

In March 2013, the Former President of the Family Council noted in an email sent to the Administrator that the minutes of the last Family Council dated September 2012 were removed from the Family Council bulletin board. On June 19, 2013, Inspector #126 interviewed S#104,she indicated that Management found out about the missing minutes when the Former President sent the email. The minutes were not initially removed by the Management Team.

On a specified day in May 2013, the Former President of the Family Council noted that the Family Council minutes of September 2012 were removed again from the bulletin board and replaced by minutes from the "Bay Ridges info night". In a response letter from the Administrator to the Former President dated May 28, 2013, the Administrator indicated that the families that participated at that information meeting took a vote to removed the old minutes of September 2012. [s. 65. (a)]

Issued on this 15th day of July, 2013

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