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

Division de la responsabilisation et de la performance du système de santé
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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 11, 2014	2014_211106_0012	MULTIPLE LOGS	Critical Incident System

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

BIRCHWOOD TERRACE
237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 7, 8, 9, 10, 2014

The following Logs were reviewed as part of this inspection: Log# S-000439-13, S-000177-13, S-000175-13, S-000174-13, S-000183-14, S-000143-14, S-000608-14 Concurrent Follow-up Inspection #2014_211106_0013 was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, RAI Coordinator, Registered Practical Nurses, Personal Support Workers, and Residents.

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed a video tape of a reported incident, licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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.) 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. (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 Health Care Record (HCR) for resident #001 was reviewed and it indicated that the resident had 5 falls in the last 38 days. The care plan document was reviewed for resident #001, and it indicated, that staff are to ensure that the bed is lowered to the floor and to place floor mats at the bedside when resident is in bed.

On July 9, 2014, at 1415hrs, inspector #106 observed resident # 001, sleeping in bed and the bed was raised approximately 18" off the floor and there were no floor mats, in place, at the bedside. On July 9, 2014, at approximately 1425, the inspector asked staff member # S-100 if the resident's bed was in the lowest position; the staff member went to the resident's room and lowered the bed to the floor. On July 10, 2014, inspector #106 asked resident #001, if staff place floor mats at their bedside when they are in bed, and the resident stated, "no, not that I can recall".

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

2. Resident # 203's plan of care was reviewed and it contains the following interventions:
-ask resident #203 if they are bored, if so suggest putting on a movie or ask if they would like to read or offer them a cup of something to drink
-"registered staff are to monitor the lounge when the PSW's are busy by bringing out the lap top and watch (203) if they are in the lounge"
-monitor and redirect resident away from residents of the opposite sex

On July 10, 2014, from approximately 0955 to 1030 hrs, inspector 106 observed the resident in the lounge/dining area, in close proximity to co-residents of the opposite sex and staff were not monitoring the resident, moving them away from co-residents of the opposite sex or offering an activity to keep them occupied. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plans of care for residents #001 and #203 is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Resident # 006 was alleged to have been abused by staff member # S-101, 4 days later, this allegation was reported to the home's DOC. The home's case notes were reviewed and the home did not inform the Director of this suspicion until 9 days after the DOC was informed of the incident, when it first submitted a Critical Incident Report report to the MOHLTC. The licensee failed to ensure that the person who had reasonable ground to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. On July 7, 2014, the Administrator provided the inspector with the "Dearness Training Schedule - 2013" which indicated when staff last had annual training regarding abuse. The Administrator also indicated which employees were currently working and which were on leave or had been terminated. The inspector reviewed the Schedule and found that 19/43 or 44% of nursing staff members had not had abuse training in the last 12 months. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in abuse recognition and prevention. [s. 76. (7) 1.]

2. On July 7, 2014, the Administrator provided the inspector with the "Dearness Training Schedule - 2013" which indicated when staff last had annual training regarding Responsive Behaviour Management. The Administrator also indicated which employees were currently working and which were on leave or had been terminated. The inspector reviewed the Schedule and found that 6/43 or 13.9%% of nursing staff members had not had Responsive Behaviour Management training in the last 12 months. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in Responsive Behaviour Management. [s. 76. (7) 3.]

3. On July 7, 2014, the Administrator provided the inspector with the "Dearness Training Schedule - 2013" which indicated when staff last had annual training regarding Fall Prevention and Management. The Administrator also indicated which employees were currently working and which were on leave or had been terminated. The inspector reviewed the Schedule and found that 18/43 or 41.8% of nursing staff members had not had Fall Prevention and Management training in the last 12 months. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in fall prevention. [s. 76. (7) 6.]

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 who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in abuse recognition and prevention, behaviour management, and fall prevention, to be implemented voluntarily.

Issued on this 11th day of July, 2014

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