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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 10, 2015	2015_339617_0009	006625-14	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

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

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

SHEILA CLARK (617)

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): May 4, 5, 6, 7, 8, 2015

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Office Manager (OM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

The inspector also conducted a tour of the home, observed resident care, and reviewed resident health care records and staff schedules.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs.

An anonymous complaint was reported to the Director regarding a resident suffering an infection due to the shortage of staff in the home. On May 4, 2015, Inspector #617 reviewed the census of the home which indicated that the subject of the complaint no longer resided in the home. During the course of the inspection, inspector #617 received multiple complaints from residents, family and staff regarding insufficient staffing.

On May 5, 2015, S #102 submitted to Inspector #617 the current staffing plan for the home. S#102 reported that the staffing plan is determined based on the care needs of the residents. Inspector #617 reviewed the staffing plan and identified that the planned deployment of Personal Support Workers (PSWs) was frequently not met. S #111 and S #102 reported the following as the planned staffing mix:
PSWs: 8 on day shift (4 on each of the 2 floors), 8 on evening shift (4 on each of the 2 floors), 4 on night shift (2 on each of the 2 floors); all shifts were 7.5 hours in length.
RPNs: 2 on day shift (1 on each of the 2 floors), 2 on evening shift (1 on each of the 2 floors), no RPNs on night shift, all shifts were 7.5 hours in length.

RNs: 1 in charge of the building on day and evening shifts, shifts were 12 hours in length.

The home had a back-up plan for staff shortages which involved re-assignment of the number of residents to PSWs to achieve equal workload. Inspector #617 interviewed S #111 who reported that staff attendance is identified via daily "Extendicare Sign In Sheets" for registered and non-registered staff. This sheet most accurately identifies staff attendance for payroll reporting and determines if staff absences were replaced to their full compliment. Inspector #617 reviewed the home's sign in sheets from March 1 to May 7, 2015 and determined the following shifts were not replaced which left the home short staffed as follows:

March
1: 3 x PSWs D, 2 x PSWs E
2: 1 x PSW D
3: 1 x PSW D, 2 x PSWs E
4: no shortage
5: 1 x PSW D, 1 x PSW E
6: no shortage
7: no shortage
8: 2 x PSW D, 2 x PSW E
9: 1 x PSW E
10: 1 x PSW D
11: 2 x PSW D, 1 x PSW E
12: 1 x PSW D,
13: 2 x PSW D, 1 x PSW E
14: 1 x PSW D
15: no shortage of PSWs
16: 1 x PSW D, 1 x PSW E
17: 1 x PSW D, 1 x PSW E
18: 1 x PSW D, 2 x PSW E
19: no shortage of PSWs
20: 1 x PSW D
21: 2 x PSW D, 2 x PSW E
22: 2 x PSW D, 2 x PSW E
23: 1 x PSW D, 2 x PSW E
24: 1 x PSW D
25: 1 x PSW D

26: 1 x PSW E
27: 2 x PSW D, 2 x PSW E
28: 1 x PSW D, 1 x PSW E
29: 1 x PSW D, 3 x PSW E
30: 2 x PSW E
31: 1 x PSW D, 2 x PSW E

April
1: 2 x PSW D, 3 x PSW E
2: 1 x PSW D, 1 x PSW E
3: 1 x PSW E
4: 2 x PSW D, 1 x PSW E
5: 2 x PSW E
6: 1 x PSW D, 2 x PSW E
7: 2 x PSW E
8: 2 x PSW E
9: 2 x PSW D, 2 x PSW E
10: 2 x PSW D, 1 x PSW E
11: 2 x PSW D, 2 X PSW E
12: 3 x PSW D, 2 x PSW E
13: 2 x PSW E
14: 2 x PSW D, 2 x PSW E, 1 x PSW N
15: 2 x PSW D, 2 x PSW E
16: 1 x PSW D, 1 x PSW E
17: 2 x PSW D, 1 x PSW E
18: 2 x PSW D, 2 x PSW E
19: 1 x RN D, 4 x PSW D, 1 x PSW E
20: 3 x PSW D, 2 x PSW E, 1 x PSW N
21: 1 x PSW E
22: 1 x PSW E
23: 1 x PSW D, 3 x PSW E, 1 x PSW N
24: 2 x PSW E
25: 1 x PSW D, 2 x PSW E
26; 2 x PSW E, 1 x PSW N
27: 2 x PSW D, 1 x PSW E
28: 2 x PSW E
29: 2 x PSW E
30: 2 x PSW E

May:
1: 2 x PSW E
2: 2 x PSW E
3: 2 x PSW E
4: 2 x PSW E
5: 1 x PSW E
6: no staff shortage
7: 2 x PSW E

Inspector #617 interviewed staff members on each of the resident care areas. Staff #107 stated that they work short all the time and the sign in sheets identify the number of sick calls without replacement. Staff #109, staff #108 and staff #106 all reported that they chronically work short with only 3 and sometimes 2 staff on day and evening shifts for both floors. During the staff shortage and following the staffing plan, the resident assignment is increased for the PSW and there is less time to provide all the care needs for the residents such as transferring with mechanical lifts, toileting and bathing. Staff #108 stated that when working short, there isn't enough help in the dining room during meal service to assist the residents with feeding. The residents who required assistance with feeding have to wait longer to eat. On May 05, 2015, at 1443hrs, inspector #617 observed the lunch meal service on the 2nd floor where 3 residents were sitting at tables and a member of the registered staff, staff #110 was assisting them to eat. It was observed that there were 2 residents left in their rooms, staff #110 reported that one of the resident's refused their meal and the other was palliative and was to remain in bed.

Staff #120 reported that when they are short staffed, staff attempt to get all the care needs completed however, if they are unable to, bathing would be delayed until the next shift or day. Staff #120 reported that when a resident's scheduled bath is missed it is indicated by not signing for it on the "Resident Care Flow Sheets". A member of the registered staff, staff #114 showed inspector #617 the resident bath schedule located at the nursing station. Inspector #617 reviewed the resident bath schedules which indicated that six residents were scheduled for a weekly bath on Monday and Thursday, May 4 & 7, 2015.
Inspector #617 reviewed the resident care flow sheets dated for the week of May 1 to 8, 2015 which indicated that five of those six residents only received one bath and one resident did not receive a bath at all during that week.

Inspector #617 interviewed staff #120 who reported that when working short and a

resident missed their bath, the PSW would communicate the information to the registered staff who record it on the "daily report record". The information is shared with the staff on the next day or evening shift to make up the bath. The made up bath would then be documented on the day it was given. Inspector #617 reviewed the daily report records from May 1 to 7, 2015 for both floors which did not indicate that missed resident baths were reported on May 4 and 7, 2015 or that an attempt was made for a make up bath.

Staff #107 reported that since February of 2014 there has been a shortage of staff with only 3 staff on days on the 3rd floor. They further stated that the staffing plan re-assigned the number of residents per PSW however the acuity level of the re-assignment is not divided equally among the 3 staff members resulting in 1 staff member assigned to most of the residents on the unit requiring 2 person care (3E has 12 residents and 3W has 3 residents who require mechanical lifts with transfer and help with toileting). [s. 31. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 11th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2015_339617_0009
Log No. / Registre no:	006625-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 10, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BIRCHWOOD TERRACE 237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WENDY SARFI

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under r. 31(3) of the LTCHA.
This plan is to include:
1. Strategies to be taken to ensure that the staffing mix is consistent with residents' assessed care and safety needs.
2. A back-up plan for nursing and the provision of personal care that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.
4. Strategies taken to ensure that missed resident care needs are addressed as a result of the operation of the back up plan when staff cannot come to work.

The Plan is to be submitted to Sheila Clark, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, via email by August 31, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing

mix that is consistent with residents' assessed care and safety needs.

An anonymous complaint was reported to the Director regarding a resident suffering an infection due to the shortage of staff in the home. On May 4, 2015, Inspector #617 reviewed the census of the home which indicated that the subject of the complaint no longer resided in the home. During the course of the inspection, inspector #617 received multiple complaints from residents, family and staff regarding insufficient staffing.

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24: 1 x PSW D
25: 1 x PSW D
26: 1 x PSW E
27: 2 x PSW D, 2 x PSW E
28: 1 x PSW D, 1 x PSW E
29: 1 x PSW D, 3 x PSW E
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3: 1 x PSW E
4: 2 x PSW D, 1 x PSW E
5: 2 x PSW E
6: 1 x PSW D, 2 x PSW E
7: 2 x PSW E
8: 2 x PSW E
9: 2 x PSW D, 2 x PSW E
10: 2 x PSW D, 1 x PSW E
11: 2 x PSW D, 2 X PSW E
12: 3 x PSW D, 2 x PSW E

13: 2 x PSW E
14: 2 x PSW D, 2 x PSW E, 1 x PSW N
15: 2 x PSW D, 2 x PSW E
16: 1 x PSW D, 1 x PSW E
17: 2 x PSW D, 1 x PSW E
18: 2 x PSW D, 2 x PSW E
19: 1 x RN D, 4 x PSW D, 1 x PSW E
20: 3 x PSW D, 2 x PSW E, 1 x PSW N
21: 1 x PSW E
22: 1 x PSW E
23: 1 x PSW D, 3 x PSW E, 1 x PSW N
24: 2 x PSW E
25: 1 x PSW D, 2 x PSW E
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27: 2 x PSW D, 1 x PSW E
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Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sheila Clark

Service Area Office /
Bureau régional de services : Sudbury Service Area Office