

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé

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

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	Licensee Copy/Copie du Titulai	re Public Copy/Copie Public			
Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection Complaint			
May 3, 4, 5, & 6, 2011	2011_106_2620_02May134049	Log# S-00659 & S-00775			
Licensee/Titulaire					
Revera Long Term Care Inc.					
55 Standish Court, 8 th Floor Mississauga, ON,					
Long-Term Care Home/Foyer de soins de le Birchwood Terrace	ongue auree				
237 Lakeview Drive, R.R.#1, Kenora, ON, P9N	J 4 17				
Name of Inspector(s)/Nom de l'inspecteur(s					
Margot Burns-Prouty (106)	-,				
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Inspection	Summary/Sommaire d'inspe	ection			
The purpose of this inspection was to con-	duct a complaint inspection.				
During the course of the inspection, the inspector spoke with: Residents, the Administrator, Environmental					
	Services Manager, Falls Coordinator, Registered Nursing Staff (RN and RPN), Personal Support Workers				
(PSW) and the Cook.					
During the course of the inspection, the inspector(s): Conducted a walk-through of all resident home areas and					
various common areas, observed care provided to residents in the home, reviewed electronic plan of care,					
reviewed written plans of care, reviewed progress notes, and interviewed staff members					
The following Inspection Protocols were used:					
	3 c u.				
,					
Snack Observation					
Dignity, Choice and Privacy					
Prevention of Abuse, Neglect and	Retaliation				
	found during this inspection.	The following action was taken:			
3 WN					
Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.					



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NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN - Written Notifications/Avis écrit

VPC - Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le Loi de 2007 les foyers de soins de longue durée à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

- 1. On May 3, 2011 during the lunch service on 3rd floor, a RPN did not ensure a resident's right to be afforded privacy in treatment when she administered eardrops to a resident in the dining area, in front of other residents.
- 2. On May 3, 2011 during the lunch service on 3rd floor, 2 RPNs did not ensure a resident's right to privacy when they were overheard discussing a recent increase in a resident's medication in the dining area, in front of other residents.
- 3. On May 3, 2011 at 1414 on 2nd floor a RPN did not ensure a resident's right to be afforded privacy in treatment when she administered eye drops to them in the lounge/dining area in front of other residents.
- 4. On May 3, 2011 at 1415 on 2nd floor a RPN did not ensure a resident's right to be afforded privacy in treatment when she administered eye drops and tooth gel to them in the lounge/dining area, in front of other residents.

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 53(1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours

Findings:

- 1. On May 4 and 5, 2011, during the lunch services, a resident was observed to spit on the floor multiple times; each time prior to spitting the resident loudly cleared their throat. The resident's plan of care was reviewed and no written strategies, including techniques and interventions, to prevent, minimize or respond to this responsive behaviour were found.
- 2. On May 4, 2011, a housekeeping staff member who was cleaning up, the resident's the spit off the floor was asked if this was recent behaviour for this resident and she stated that "they had only been doing this for the last month or so".

WN #3: The Licensee has failed to comply 71(3) The licensee shall ensure that each resident is offered a minimum of,

(c) a snack in the afternoon and evening.

Findings:

1. On May 3, 2011, on the second floor 8 residents, who were in there rooms, were not offered a snack during the afternoon nourishment pass. Inspector 106 observed the nourishment cart from 15:00, when staff began the nourishment pass, until 16:00, when it was removed from the unit.



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The cart was not observed to be taken by staff down the East hall to offer those residents a snack during that time.

			TED NON-COMPLIANCE respects à Corrigé	
REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	Action/ Order#	INSPECTION REPORT #	INSPECTOR ID#
LTCHA, 2007, S.O. 2007 c. 8, s.15(2)(a)	WN	1	2010_106_2620_13Sep115605	106

	e or Representative of Licensee e du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
		Marin .
Title:	Date:	Date of Report: (if different from date(s) of inspection). July 20, 2011