Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 16, 17, 18, 19, Feb 3, Mar 15, 16, 2012	2012_051106_0001	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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Quality and Staff Education Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers (SDM) and Residents

During the course of the inspection, the inspector(s) Conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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 subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. On January 19, 2012, a Power of Attorney (POA) for a resident, told inspector 106 that on December 25, 2011 at approximately 1930 hours they asked "the nurse who was giving out meds" to send the resident for an x-ray that day, as the resident was in pain due to a fall the previous day. The POA provided a physical description of the staff member they spoke to, this description was a match for both RNs that were working December 25, 2011. The resident was not transferred to hospital for further assessment until December 26, 2011, on December 27, 2011 they received a CT scan and was diagnosed with multiple fractures. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the plan of care. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (5)] (106)
2. On December 24, 2011, a resident had an unwitnessed fall. No documentation was found to support that the home notified the family of the fall. During a January 18, 2012 interview, the DOC stated that, the resident notified their family the next day of their fall. The family stated during the intake for this complaint that they were not notified of the fall until December 25, 2011 by staff. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the plan of care. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (5)] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. A resident had a fall on December 24, 2011. On January 18, 2012, the DOC told inspector 106 that a "Post Falls Skills Checklist" is to be completed for every fall sustained by a resident in the home. A completed "Post Falls Skills Checklist" was not found for the resident's December 24, 2011, fall. The licensee failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [O. Reg. 79/10, s. 49 (2)] (106)

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. On December 26, 2011, a resident was transferred to hospital due to an injury from a fall, the home did not submit a report, regarding this critical incident, until December 28, 2011. The licensee failed to ensure that the Director was informed no later than one business day when a resident sustained an injury in respect of which they were taken to hospital. [O. Reg. 107 (3) (4)] (106)

Issued on this 20th day of March, 2012

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