



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 prévue le Loi de 2007 les foyers de soins de longue

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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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
Jun 4, 5, 6, 7, 8, Aug 9, 10, 13, 14, 16, 2012	2012_051106_0015	Critical Incident

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 inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), 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:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

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.)	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 subsections:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Progress notes for resident #010, from March 13, 2012 to June 4, 2012, were reviewed by inspector 106. There were 57 separate incidents where staff documented that resident #010 was behaving inappropriately and required redirection or intervention. The most recent RAI MDS assessment for resident #010 is dated February 5, 2012. A focus regarding the nature of resident behaviours was created in resident #010's plan of care on January 2, 2012, none of the interventions under this focus have been revised since that date. Staff interviewed stated that they manage resident #010 behaviours, through monitoring and redirection. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan has not been effective. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (c)] (106)

2. On June 7 and 8, 2012, resident #011 was observed by inspector 106 to exhibit responsive behaviours. Staff were observed to monitor the resident and to redirect one specific male resident. Staff did not encourage the resident to take part in diversional activities such as wiping tables with spray bottle of water and clean cloth and/or folding towels as specified in their plan of care. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

3. The RAI MDS assessment dated March 29, 2012 for resident #012, indicates, they do not have any behavioural symptoms. Two Mandatory Reports (MR) indicate that resident #012 became physically and verbally aggressive with co-resident #013 on two separate occasions. Resident #012's plan of care does not contain focuses or interventions that manage the resident's aggression towards co-residents. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (10) (b)] (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 the care set out in the plan of care is provided to the resident as specified in the plan; that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary or care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping
Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On June 7 and 8, 2012, inspector 106 noted a very strong urine odour in a resident's room. The licensee failed to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. [O. Reg. 79/10, s. 87 (2) (d)] (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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours
Specifically failed to comply with the following subsections:

s. 53. (3) The licensee shall ensure that,

(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. On June 5, 2012, staff member #S-100, reported to inspector 106, that the home does not currently have a responsive behaviours program. The licensee failed to ensure that a responsive behaviours program, as referred to in O. Reg. 79/10, s. 53 (1), was developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [O. Reg. 79/10, s. 53 (3) (a)] (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 a responsive behaviours program, as referred to in O. Reg. 79/10, s. 53 (1), is developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect
Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Three mandatory reports, submitted to the ministry, indicate that, resident #011 (who is cognitively unaware) was sexually abused by resident #010 (who is cognitively aware). Two previous critical incident reports were submitted to the ministry, both reporting inappropriate sexual behaviour by resident # 010, towards resident #011. There are also numerous progress notes documenting inappropriate behaviours between these two residents. The home has failed to protect resident #011 from sexual abuse by resident #010. The licensee failed to protect residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff. [LTCHA, 2007, S. O. 2007, c.8, s. 19 (1)] (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 residents are protected from abuse by anyone and to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. On June 5, 2012, staff member #S-100 provided inspector 106 copies of the home's written abuse policies. "Resident Non-Abuse (Ontario)", index # LP-B-20-ON, under "INVESTIGATION" in paragraph 4, indicates, "The ED will maintain confidential files that will include any statements, interview/meeting minutes, and other documentation related to, or generated by, the investigation." On June 5, 2012, inspector 106 requested to see the documentation of the investigation of sexual abuse of resident #011 by resident #010 as indicated in three Mandatory Reports. On June 6, 2012, staff member # S-100 provided "briefing notes" (a short summary of the incident) that had been cut and pasted from reports that had been sent to the home's corporate office. These notes did not include any statements, interview/meeting minutes or other documentation related to, or generated by, the investigation. The licensee failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of resident and ensured that this policy was complied with. [LTCHA, 2007, S. O. 2007, c. 8, s. 20 (1)] (106)
2. On June 5, 2012, staff member #S-100 provided inspector 106 copies of the home's written abuse policies. "Resident Non-Abuse (Ontario)", index # LP-B-20-ON, under "INVESTIGATION" in paragraph 4, indicates, "The ED will maintain confidential files that will include any statements, interview/meeting minutes, and other documentation related to, or generated by, the investigation." On June 5, 2012, staff member #S-100, reported that the home did not conduct an investigation into the alleged financial abuse of resident #021, other than submitting the online Mandatory Report. There were no confidential files regarding this incident of suspected financial abuse and its investigation. The licensee failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of resident and ensured that this policy was complied with. [LTCHA, 2007, S. O. 2007, c. 8, s. 20 (1)] (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #6: 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 subsections:

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.**
- 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.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits saillants :

1. A Mandatory Report, was reviewed by inspector 106, the report indicates that an incident of sexual abuse occurred at 21:30 h, but this incident was not reported to the Director until the next day at 15:26 h. The licensee failed to ensure that the person who had reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported those suspicions and the information upon which it was based to the Director. [LTCHA, 2007, S. O. 2007, c. 8, s. 24 (1) 4] (106)
2. A Mandatory Report, was reviewed by inspector 106, the report indicates that an incident of misappropriation of a resident's money occurred, but this incident was not reported to the Director until two days after it occurred. The licensee failed to ensure that the person who had reasonable grounds to suspect that the misuse or misappropriation of a resident's money had occurred or may occur, immediately reported those suspicions and the information upon which it was based to the Director. [LTCHA, 2007, S. O. 2007, c. 8, s. 24 (1) 4] (106)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service
Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,

- (a) procedures are developed and implemented to ensure that,**
 - (i) residents' linens are changed at least once a week and more often as needed,**
 - (ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
 - (iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
 - (iv) there is a process to report and locate residents' lost clothing and personal items;**
- (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;**
- (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and**
- (d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).**

Findings/Faits saillants :

1. On June 8, 2012 at 1130, inspector 106 observed the bottom sheet on the bed nearest the window, in a resident's room to be thread bare and was "see through" in large areas. The licensee failed to ensure that linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours. [O. Reg. 79/10, s. 89 (1) (c)] (106)

Issued on this 17th day of August, 2012

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

