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
Jun 4, 5, 6, 7, 8, Aug 8, 9, 10, 2012	2012_051106_0014	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), 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:

Personal Support Services

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 subsections:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 plan of care for resident #001 specifies, "Complete skin inspection BID and report any open areas, reddened area, bruises, etc. to RPN or RN". Bruising to resident #001 was first discovered and documented by staff member #S-102 on January 23, 2012. Staff member #S-103 assessed the bruising on January 25, 2012 and documented that they felt the bruising was not acute,and occurred in the last week. The licensee failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)
2. The plan of care for resident #001 indicates, "Place floor pads beside bed to minimize risk of injury". On June 7, 2012, inspector 106 observed staff transfer resident #001 into bed and they did not piace floor pads at the bedside. Inspector 106 asked the staff members if the resident uses floor mats and they stated that resident #001 does not use a floor mat. The licensee failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)
3. The January 2012, "Daily Documentation Record" for resident #001, is ticked/checked a minimum of one time each day to indicate "Skin dry and itchy". It is also ticked/checked a minimum of once per day to indicate "Skin tear/ bruise/ cut/ redness/ black area" on the following days: January 17, 18, 20-31, 2012. This record has been initialed by each PSW providing care to this resident for every shift during the month of January 2012, with the exception of January 19, 2012, day shift.
During an interview on June 6, 2012, staff member #S-104 showed inspector 106 the "Resident Skin Observation Record" and stated this form is filled out by PSWs when they note changes to a resident's skin and then it is brought forward to registered staff. During an interview on June 8, 2012, with staff member #S-105, they reported that the January 2012 "Resident Skin Observation Record" in resident #001's chart was blank and had not been filled out by staff.
During an interview on June 6, 2012, staff member # S-102 reported that no staff member reported the bruising to resident #001 prior to her finding the bruising on January 23, 2012. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (4) (a)] (106)
4. A progress note dated January 23, 2012 at 1115 h, for resident #001 indicates the resident was assessed, bruising of an unknown origin was found and that the DOC was notified. On January 24, 2012, at approximately 1300 h, while assisting the resident with lunch the resident's SDM noted bruising to the resident. No documentation was found to indicate that the resident's SDM had been notified of this injury, prior to January 24, 2012 at approximately 1300 h. The licensee failed to 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. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (5)] (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 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; that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. On June 6, 2012, prior to 0600 h, Staff member #S-100 informed inspector 106 that resident #003 had been washed by the night staff but left in bed due to current health status. A memo dated January 23, 2012, directs staff to ensure that resident #003 is washed before the day shift starts at 0600 h. The plan of care was reviewed for resident #003 and it provides staff with direction regarding when resident goes to bed however, the plan of care does not contain any reference in regards to this resident's wake time or sleep preferences. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [O. Reg. 79/10, s. 26 (3) 21] (106)
2. A memo dated May 15, 2012, directs staff to ensure that resident #006 is washed and up before the day shift starts at 0600 h. The plan of care was reviewed for resident #006 and it did not contain any references in regards to sleep patterns or preferences. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [O. Reg. 79/10, s. 26 (3) 21] (106)
3. On June 6, 2012, at 0510 h, inspector 106 observed 2 PSWs dressing resident #004. A January 23, 2012, memo directs staff to have resident #004 "washed and up in chair", having am care provided by the night shift. The plan of care was reviewed for resident #004 and it did not contain any references in regards to sleep patterns or preferences. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [O. Reg. 79/10, s. 26 (3) 21] (106)
4. On June 6, 2012 at 0515 h, inspector 106 observed 2 PSWs enter resident #005's room, turn on the bathroom light, run the bathroom faucet, turn on the light above the resident's head and state to the resident who was asleep, "We are going to wash up now, is that okay?". The resident mumbled yes, one PSW began to provide care and the other left the room. A memo dated January 23, 2012, indicates that resident #005 is to be "washed and up in chair" by the night shift. The plan of care was reviewed for resident #005 and it did not contain any references in regards to sleep patterns or preferences. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [O. Reg. 79/10, s. 26 (3) 21] (106)
5. A memo dated May 15, 2012, directs staff to ensure that resident #007 is washed and up before the day shift starts at 0600 h. The plan of care was reviewed for resident #007 and it did not contain any references in regards to sleep patterns or preferences. On June 7, 2012, inspector 106 asked resident #007 if staff wake them up prior to 0600 every morning and they stated yes. Inspector 106 then asked resident #005 if they would prefer to be woken up later they stated, yes, of course. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [O. Reg. 79/10, s. 26 (3) 21] (106)
6. On June 6, 2012, at approximately 0535 h, inspector 106 observed 2 PSWs providing am care for resident #001. A May 15, 2012, memo directs night staff to have resident #001, washed and ready for days to get them up every am. The plan of care for resident #001 was reviewed and there was no references found regarding the resident's sleep patterns and preferences. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [O. Reg. 79/10, s. 26 (3) 21] (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 plan of care must be based on, at a minimum, interdisciplinary assessment of sleep patterns and preferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On June 7, 2012, inspector 106 interviewed 2 PSWs and 1 RPN regarding the January 23 and May 15, 2012 memos that direct night staff to provide am care to specific residents before they end their shift at 0600 h. Both PSWs stated that the residents are provided am care prior to 0600 h for staff convenience and not for the benefit of the residents. The RPN stated that it is done to help the day shift as they would not be able to get everyone up without the help. The licensee failed to ensure that every resident's right to have his or her participation in decision-making respected is fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 9] (106)
2. On June 6, 2012, staff member #S-101 reported to inspector 106 that night staff have a list that directs which residents they are to get up prior 0600. When asked what does staff do if the resident does not want to be woken up prior to 0600 h, such as resident #001, the PSW, hesitated and smiled uncomfortably. Inspector then asked asked if they get them up anyway and staff member # S-101 stated they do as this is management's direction. The licensee failed to ensure that every resident's right to have his or her participation in decision-making respected is fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 9] (106)
3. On June 6, 2012 at approximately 0535 h, inspector 106 observed staff member #S-101 enter resident #001's room. Both residents were asleep, staff member #S-101 woke resident #001 up and asked the resident if they were ready to get up. Resident #001 mumbled "no", the staff member chuckled and repeated "no?" to the resident. Staff member #S-101 then said "I am going to wash your face" and proceeded to do so. During the am care resident #001 was grimacing, frowning and mumbling as the staff member continued to wash their face. A second staff member came to assist with resident #001's care and the resident stated "that's freezing" as the staff members were washing resident #001 up. Once resident #001 was washed and dressed they were laying in bed with their eyes closed and appeared to have fallen back to sleep and staff member #S-101 began brushing resident #001's teeth with an electric toothbrush, to which resident #001 grimaced and frowned. The licensee failed to ensure that every resident's right to have his or her participation in decision-making respected is fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 9] (106)
4. On June 6, 2012, inspector 106 arrived at the home 0507 h and observed residents already dressed and up in their chairs or being provided am care or woken up to be provided am care, all prior to 0600 h by the night shift.(resident # 001, 003, 004, 005, 006, 007) The licensee failed to ensure that every resident's right to have his or her participation in decision-making respected is fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 9[(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 every resident's right to have his or her participation in decision-making respected, specifically the time they wake up in the morning is fully respected and promoted, to be implemented voluntarily.

Issued on this 17th day of August, 2012

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