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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2013	2013_211106_0001	929-12, 952-12	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.

This inspection was conducted on the following date(s): January 9, 2013

Log # S-000929-12

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), 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:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Medication

Pain

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. During an interview on January 9, 2013, with resident #001 they identified that staff regularly do not put their clothes out for them to change into for the next day. On January 9, 2013, staff member #S-100 reported that the night staff are to lay out the resident's day clothes, but they often do not do this. A RAI MDS quarterly assessment for resident #001, identifies that the resident has physical limitations and requires the assistance of one-person for dressing and personal hygiene. On January 9, 2013, at 1030 h during an interview with the inspector, resident #001 indicated they would prefer to be dressed in their day clothes, at 1100 h the resident was observed to be still dressed in their night clothes. The licensee failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. [s. 40.]

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 each resident of the home and specifically resident #001, are assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.

WN #2: 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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. On January 9, 2012 staff member #S-100 and staff member #S-101, both reported to inspector that the night staff are to lay out resident #001 day clothes for the next day. The plan of care for Resident #001 was reviewed and it does not contain any interventions that direct night staff to lay out the next day's clothes for the resident. The licensee failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident. [s. 6. (1) (a)]

2. On January 9, 2013, inspector 106 observed that resident #001 had a moderate amount of facial hair in excess of 4 mm. During a January 9, 2013 interview with staff member #S-100, reported that the resident has an electric razor, but will become angry if staff point out the facial hair and will also become angry if staff attempt to brush the resident's hair or teeth. The plan of care for resident #001 was reviewed and no interventions or strategies were found that provide staff with clear direction on what staff are to do when the resident becomes angry and resists care assistance. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. On January 9, 2013 at approximately 0915 h, during a tour of the home, inspector observed, the bed closest to the window in a resident room was unmade and had a large dried urine stain in the center of the bottom sheet on the bed. At 1145 h, the inspector returned to the room, the bed was made; staff member #S-102 was asked if the linens had been changed. Staff member #S-102 stated they had not and that they would be changed when the resident has their bath, staff member #S-102 was unsure of the day this would occur. Inspector explained that they had noted earlier that the unmade bed had a dried urine stain, and pulled the blankets back to observe the bottom sheet, the urine stain was still on the bottom sheet. The Licensee failed to ensure that procedures are developed and implemented to ensure that, residents' linens are changed at least once a week and more often as needed. [s. 89. (1) (a) (i)]

Issued on this 7th day of March, 2013

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