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

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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
Apr 23, 2013	2013_168202_0021	T-1008-12,T -1229-12	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

OAK TERRACE
291 MISSISSAGA STREET WEST, ORILLIA, ON, L3V-3B9

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

VALERIE JOHNSTON (202)

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): April 11, 12, 15, 16, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Regional Manager of Education and Resident Services, Ward Clerk, Registered Nursing Staff, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, staffing schedules and resident bath/shower schedules

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s.33.(1)].

Staff interviews confirmed that all residents in the home are to be provided two baths/showers per week, however if a staff member is absent from the home due to a 'call in', all scheduled baths will not be provided and are not rescheduled. Resident's who miss their bath due to 'short staffing' will only receive a bath/shower on that resident's next scheduled bath day.
During the course of this inspection on April 11, 12, 15, 16, 2013, residents were interviewed throughout the home. Resident #002 revealed that when staff are short or they do not have time, he/she will not be provided a bath. A review of resident #002's clinical records revealed that a bath is scheduled for this resident each Tuesday and Friday. The scheduled bath was not provided for resident #002 on January 15, 22, February 01, 19, 26, March 25, 28, 30 and April 02, 06, 13, 2013.
Resident #003 confirmed that he/she did not receive his/her scheduled bath for April 11, 2013 and indicated that this happens often. Resident #003 revealed that his/her bath is only provided when there is enough staff available and if the staff have time to provide his/her bath. Resident #003's clinical records indicate that a bath is scheduled for each Tuesday and Thursday and was not provided on January 03, 08, 10, 15, 17, 22, 24, and April 11, 2013.
Resident #004 confirmed that he/she did not receive his/her scheduled bath on April 11, 2013 and indicated that he/she usually only receives one bath per week because the staff are short each week. Resident #004's clinical records indicate that a bath is scheduled for each Sunday and Tuesday and was not provided a bath on March 05, 12, 19, and April 07, 11, 2013.
Resident #005 revealed that he/she will receive a bath about once per week, when the staff have time and will wash him/herself at the sink in the bathroom. Resident #005's clinical records confirmed that a bath is scheduled for each Monday and Thursday and was not provided a bath on January 03, February 11, 25, March 28 and April 11, 2013.
Resident #007 revealed that when staff are short he/she will not be provided a bath, will then have to wash him/herself in the sink and wait for the next time his/her bath is scheduled. Resident #007's clinical records confirmed that a bath is scheduled for each Wednesday and Sunday and was not provided a bath on January 02, February 09, 13, March 09, 13, 2013.

Staff interviews and staffing scheduled revealed that on April 11 and 12, 2013 the home was short one Personal Support Worker on both day shifts. Staff interviews confirmed that the 6 resident baths that were scheduled on Thursday April 11, 2013 and Friday April 12, 2013 were not provided to the residents according to schedule and were not rescheduled. [s. 33. (1)]

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 bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times. [s. 8.(3)]

A review of the staffing schedule for January 2012-April 2013 and an interview with the Ward Clerk on April 12, 2012 confirmed that a Registered Nurse was not on duty and present in the home on the following night shifts:
March 23, 2012, March 24, 2012, April 01, 2012, April 06, 2012, May 18, 2012 [s. 8. (3)]

Issued on this 24th day of April, 2013

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