Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton, ON L8P 4Y7

Telephone: 905-546-8294
Facsimilie: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Quest, 11iém étage
Hamilton, ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

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Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 28, 2011	2011-120-2581-28JAN082421	H-03077 - Criticial Incident

Licensee/Titulaire

Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

Baywoods Place, 330 Main Street E., Hamilton, ON L8N 3T9

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

Bernadette Susnik, Long Term Care Homes Inspector – Environmental Health #120

Inspection Summary / Sommaire d'inspection

The purpose of this inspection was to conduct a follow-up to a Critical Incident.

During the course of the inspection, the above noted inspector spoke with the Administrator, Assistant Director of Care, Environmental Services Supervisor, registered nursing staff and personal service workers. During the course of the inspection, a walk-through was conducted of the 3rd, 4th and 5th floors which included resident rooms and their ensuite washrooms, tub rooms, dining rooms and lounge spaces.

The following Inspection Protocol was used during this inspection:

- *Safe and Secure Home*

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: ***The licensee has failed to comply with LTCHA 2007, S.O., 2007, c.8, 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.

Findings:

Interventions to mitigate risks related to an identified resident's environment were not taken after they were relocated from one room to another room .

The resident's plan of care, last updated on January 15, 2010, indicates that their environment needs to be clutter and object-free, to prevent them from "pulling items off counters or turning on water faucets, causing flooding". The intervention taken was to turn the hot water off in their bathroom at the handsink. The tub that was also located in their bathroom, did not have any faucets. The home took an initiative over 5 years ago to remove all of the tub faucets from the tubs located in each resident room.

In 2010, the resident was relocated from one room to another room. Their new room was not assessed for environmental risks. The resident's plan of care was not followed when they were relocated. The bathroom in an identified room had a tub with faucets that were operational. It is not known exactly when the faucets were re-installed, however the floor staff who were questioned, knew that the room had functional faucets. Subsequently, in 2010, the resident was found lying unharmed in the tub in several inches of water.

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 in respect to ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Revised for the purpose of publication - Sept 29, 2011
Title: **Date:**	**Date of Report (if different from date(s) of inspection).**