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**
**Direction de l'amélioration de la performance et de la conformité**

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119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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119, rue King Ouest, 11iém étage
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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 22, 27, Jul 18, 2011 | 2011_064167_0006 | 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**

BAYWOODS PLACE
330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9

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

MARILYN TONE (167)

## 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 the Director of Care, staff on the unit where the identified resident resided, staff members who were involved in or had knowledge of the incident involving the identified resident.**

**During the course of the inspection, the inspector(s) conducted a review of the health record for the identified resident, reviewed the home's policies and procedures related to Falls Prevention including post falls Care, Restraints and Bedrails, Safe lifts and transfers and reviewed the education program provided to staff related to safe transferring and positioning.**
**The inspector also conducted a review of the equipment where the incident took place and a re-enactment of the incident as reported took place.**

**The following Inspection Protocols were used in part or in whole during this inspection:**

**Falls Prevention**

**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Definitions | Définitions |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (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;**
**(b) the goals the care is intended to achieve; and**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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 sayants :**

1. s. 6(1)c The plan of care for the identified resident did not give clear direction to staff related to the use of bedrails when the resident was in bed.

a) The document that the home refers to as the care plan for the identified resident identifies that bedrails are used to facilitate transfers. The care plan also indicates that the identified resident requires the use of a mechanical lift for transfers. There is no direction on the identified resident's care plan related to the use of bedrails as a restraint.
b) When the identified resident sustained a fall, it was noted by the personal support worker who was providing care to them that the bedrails on the resident's bed were both in the raised position when the personal support worker entered the room.
c) A personal support worker interviewed who regularly works on the identified resident's unit confirmed that bedrails were always raised when the identified resident was in bed and were used to prevent them from climbing out of bed.

s. 6(7) The care set out in the identified resident's plan of care was not provided to them as specified in the plan.

a) The plan of care for the identified resident indicates that they are at high risk for falls and when the fall involving the identified resident took place, it was noted that the bed was in it's high position.
b) The staff member who was providing care when the fall occurred confirmed that the bed was in it's high position when they entered the room just prior to the fall and that they had not elevated or lowered the bed.
c) The identified resident's plan of care directs staff to have the bed in it's lowest position when the resident is in bed and to use a falls mat and a bed alarm.
d) The plan of care for the identified resident indicates that they require transfer with a mechanical lift and two staff assist. When the identified resident sustained the fall, the staff member did not used a mechanical lift and two staff assist to transfer the resident as directed in their plan of care.

*Additional Required Actions:*

*CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".*

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

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**Findings/Faits sayants :**

1. A staff member did not use safe transferring and positioning technique when providing care to an identified resident resulting in a fall and injury.

a) The document that the home refers to as the care plan for the identified resident indicates that they require a mechanical lift and two staff assist for transfers and are at high risk for falls.
b) The identified resident's health conditions were not taken into consideration when care was being provided to the resident.
c) The personal support worker who was providing care to the identified resident did not provide safe positioning of the resident when providing care or the assessed transferring technique when transferring the resident.

*Additional Required Actions:*

*CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".*

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining Specifically failed to comply with the following subsections:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:**
**1. Restrained, in any way, for the convenience of the licensee or staff.**
**2. Restrained, in any way, as a disciplinary measure.**
**3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.**
**4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.**
**5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**

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**Findings/Faits sayants :**

The identified resident was restrained by use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

a) The bedrails for the identified resident were routinely elevated to prevent them from climbing out of bed and inhibited their ability to get out of the bed.
b) A personal support worker interviewed who regularly works on the identified resident's unit confirmed that the bedrails were always raised when the resident was in bed and were used to prevent the resident from climbing out of bed.
c) The use of the bedrails for the purpose of preventing the identified resident from getting out of bed was not included in their plan of care in accordance with section 31 of the Act.

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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**Specifically failed to comply with the following subsections:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits sayants :**

1. s. 8(1)b The licensee did not ensure that their policy and procedure related to post falls care was complied with when the identified resident sustained a fall.
a) The home's policy N-75- appendix DD from the manual referred to as F.I.R.M ( Fall Intervention Risk Management ) states "do not move the resident if you suspect a serious injury".
b) When the fall involving the identified resident occurred, the personal support worker who was providing care to the resident did not follow the direction set out in this policy.

**Issued on this 28th day of July, 2011**

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

Marilyn Lore

Ontario

**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

# Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
*Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

| | | | |
|---|---|---|---|
| | ☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public** | | |
| **Name of Inspector:** | MARILYN TONE | **Inspector ID #** | 167 |
| **Log #:** | H-00229-11 | | |
| **Inspection Report #:** | 2011_064167_0006 | | |
| **Type of Inspection:** | Critical Incident | | |
| **Date of Inspection:** | June 22, 24 & 27, 2011 | | |
| **Licensee:** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 | | |
| **LTC Home:** | BAYWOODS PLACE<br>330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9 | | |
| **Name of Administrator:** | Dian Shannon | | |

To Revera Long Term Care Inc., you are hereby required to comply with the following order by the date set out below:

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|---|---|---|---|
| **Order #:** | 01 | **Order Type:** | Compliance Order, Section 153 (1)(b) |

**Pursuant to: 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. 2007, c. 8, s. 6 (7).**

**Order:**

The licensee shall prepare, submit and implement a plan to ensure that all residents who are at risk for falls receive the care related to falls prevention that is set out in their plans of care. The licensee should prioritize residents at greatest risk. The plan shall be submitted to Marilyn Tone, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 by August 5, 2011.

**Grounds:**

s. 6(7) The care set out in the identified resident's plan of care was not provided to them as specified in the plan.

a) The plan of care for the identified resident indicates that they are at high risk for falls and when the identified resident sustained the fall, the bed was noted to be in it's high position.
b) The staff member who was providing care when the fall occurred confirmed that the bed was in it's high position when they entered the room just prior to the fall and that they had not elevated or lowered the bed at any time.
c) The identified resident's plan of care directs staff to have the bed in it's lowest position when the resident is in bed and to use a falls mat and a bed alarm.
d) The plan of care for the identified resident indicates that they require transfer with a mechanical lift and two staff assist. When the identified resident sustained the fall, the staff member providing care did not use a mechanical lift and two staff assist to transfer the resident as directed in the resident's plan of care.

| **This order must be complied with by:** | August 25, 2011 |
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| **Order #:** | 02 | **Order Type:** | Compliance Order, Section 153 (1)(b) |
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**Pursuant to: Ontario Regulation 79/10, s. 36.**

**Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.**

**Order:**
The licensee shall prepare, submit and implement a plan to ensure that staff use safe positioning and transferring devices and techniques when assisting residents.
The plan shall be submitted to Marilyn Tone, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 by August 5, 2011.

**Grounds:**

A staff member did not use safe transferring and positioning technique when providing care to an identified resident resulting in the resident sustaining a fall and an injury

a) The document that the home refers to as the care plan for the identified resident indicates that they require a mechanical lift and two staff assist for transfers and are at high risk for falls.
b) The identified resident's health conditions were not taken into consideration when care was being provided to the resident.
c) The personal support worker who was providing care to the identified resident did not provide safe positioning of the resident when providing care or the assessed transferring technique when transferring the resident.

Ontario

**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

| **This order must be complied with by:** | August 25, 2011 |
|---|---|

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

**Director**
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

**Health Services Appeal and Review Board and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

**Director**
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

| Issued on this 27th day of July, 2011 | |
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| Signature of Inspector: | Marilyn Lowe |

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|---|---|
| Name of Inspector: | Marilyn Tone |
| Service Area Office: | Hamilton |