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
Mar 15, 19, 20, 21, 22, 26, 2012	2012_027192_0007	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

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

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

DEBORA SAVILLE (192)

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 residents on multiple home areas, the Executive Director, Director of Nursing, Associate Director of Nursing, Resident Services Coordinator/Education Coordinator, Registered Practical Nurse, Personal Support Workers, and Environmental Aides related to H-002150-11, H-002499-11 and H-000145-12.

During the course of the inspection, the inspector(s) reviewed medical records, complaint investigation notes, incident reports and investigation notes, and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Personal Support Services

Reporting and Complaints

Skin and Wound Care

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to a specified resident, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

a) A resident change of status form in the progress notes indicates that the specified resident was hospitalized on a specified date in 2011.
The medical record does not include documentation of any change in condition, assessment or reassessment, that the resident was transferred to hospital, the location of the hospital or the reason for transfer. The first note following transfer to hospital is two days following admission to hospital, indicating the home does not know which hospital the resident is in.
Interview with the Director of Care confirms that documentation from this time frame is absent and that agency staff were working at the time of the transfer. E-mail to the agency confirms that the staff educator of the home contacted the agency, but no record of the events that led up to the transfer, the transfer, or location of the resident was requested.
Documentation related to the specified resident's change in condition, assessment, reassessment, and transfer to hospital on the specified date in 2011 were not documented in the medical record.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

a) On a specified date in 2012 a person called the home to complain about the care a family member received on a specified date in 2012 prior to transfer to hospital for exacerbation of a disease process. At the time of the call the person spoke with the Resident Services Coordinator/Education Coordinator. She was advised that the Administrator would get back to her.

b) Interview with the Resident Services Coordinator/Education Coordinator confirmed that a call was received from this family member on the specified date in 2012 expressing concerns about the care a specified resident received on a specified date in 2012.

c) No further record of the complaint could be provided by the home. The home's policy indicates that complaints are to be recorded on the Client Services Response Form, a copy forwarded to the administrator and to the department manager responsible for addressing the concern. No Client Services Response Form could be provided related to the specified 2012 complaint.

d) Interview confirms that no action was taken related to the concerns expressed by the complainant.

e) The same complainant expressed concern on a specified date in 2011, about staff knowledge of the location of the resident and the frequency of hospital admissions. A Client Services Response Form was initiated by the home but does not include information related to the investigation and resolution of the concerns. There is no indication that the complainant received a response to these concerns.

f) On a specified date in 2012 another complainant expressed concern about an unreported fall that occurred as a result of a staff members actions. The fall allegedly resulted in bruising and pain exacerbated from a previous injury. Investigation was initiated into this concern, although the last documentation indicates that a staff member remained off on paid leave as the investigation continues. There is no documentation that the investigation was completed or that the complainant was notified of the results of the investigation. A note for a specified date in 2012 indicates a message was left for the complainant. No further documentation of the completion of the investigation or communication with the complaint is evident.

Issued on this 4th day of April, 2012

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

Debra Saville (192)