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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Oct 29, 2013	2013_216144_0077	L-000566-13	Critical Incident System

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

BANWELL GARDENS
3000 BANWELL ROAD, P. O. BOX 3246, TECUMSEH, ON, N8N-2M4

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 16, 2013

During the course of the inspection, the inspector(s) spoke with one resident and their Power of Attorney, the Administrator, Director of Nursing and Personal Care, one Registered Nurse, two Registered Practical Nurses and three Personal Service Workers.

During the course of the inspection, the inspector(s) reviewed one critical incident report, resident health record and the home's policies related to Abuse or Neglect and Pain Management.

The following Inspection Protocols were used during this inspection:
Pain

Prevention of Abuse, Neglect and Retaliation

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.) 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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. When one resident's pain was not relieved by initial interventions, a pain assessment was not completed using a clinically appropriate assessment instrument specifically designed for this purpose.
- One registered staff documented in the physician's communication book that the resident's current analgesic medication was not effective for pain management and requested a change in the medication or medication dose.
- Medication changes were initiated ten days after the request was made.
- The resident health record confirmed the resident had not had a pain assessment using a clinically appropriate assessment instrument for the past three months.
- The resident and three staff confirmed the resident experiences pain when care is being provided. [s. 52. (2)]

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 related to ensuring when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s.3. (4) The Lieutenant Governor in Council may make regulations governing how rights set out in the Residents' Bill of Rights shall be respected and promoted by the licensee. 2007, c. 8, s. 3 (4).

Findings/Faits saillants :

1. The licensee did not ensure that one resident's right to be cared for in a manner consistent with their needs was fully respected and promoted.
- Nursing staff documented in the physician's communication book that the resident's current analgesic medication was not effective for pain management.
- The physician reviewed and revised the resident's analgesic medication ten days later.
- The resident health record confirmed the resident complains of pain at specific sights.
- The resident and three staff confirmed the resident experiences pain when care is being provided. [s. 3. (4)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a person who has reasonable grounds to suspect any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.
- One resident reported to nursing personnel that she had been treated in a disrespectful and rough manner by one staff.
- The Director was not notified of the allegation through the Critical Incident Reporting System as required until ten days after the allegation was made. [s. 24. (1) 1.]

Issued on this 29th day of October, 2013

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

CAROLEE MILLINER

Alison Spence-Falkingham