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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Mar 19, 20, 21, 22, 23, 2012	2012_043157_0009	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

BAY RIDGES
900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4

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

PATRICIA POWERS (157)

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 the home's Administrator, Director of Care, Associate Director of Care, Program Manager, one Registered Practical Nurse, 3 Personal Support Workers, a family member of an identified resident, and a private care provider.

During the course of the inspection, the inspector(s) reviewed the clinical health record of an identified resident, reviewed the report of a Critical Incident related to an identified resident, reviewed the home's personnel records related to four Registered Practical Nurses.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. An identified resident's Power of Attorney (POA)was advised that the resident was being transferred to hospital for x-rays. There is no evidence that the POA was informed of the nature or cause of the resident's injury. [O.Reg 79/10,s.107 (5)]
2. A Critical Incident Report report (CI Report) reports that a "head to toe assessment completed" for an identified resident. There is no evidence in the clinical record that a head to toe assessment was completed nor is there a record of the outcome of an assessment. A progress note entry provides only a description of an injury sustained by the resident.[O.Reg 79/10,s.107(4)3.i.]
3. The critical incident (CI) resulting in an injury to an identified resident was reported. The report stated "Will amend this report with outcome". The CI report was not amended to provide the outcome/current status of the resident or to report an unexpected death resulting from an accident. [O.Reg 79/10,s.107(4)3.v.]
4. The CI Report does not provide the name of the person who was present at the time of the incident, or the name of a Personal Support Worker who allegedly discovered the incident. [O.Reg 79/10,s.107(4)2.ii.]
5. The CI Report describes the events leading up to an incident resulting in the injury of an identified resident. The employee who confirmed that she completed the report states she reported what she was told and she did not investigate the incident. There was no investigation to provide an accurate description of the incident, the type of the incident, the date and time of the incident or to accurately determine the events leading up to the incident.[O.Reg 79/10, s.107(4)1.]
6. Entries in the progress notes for an identified resident state that the home was made aware of resident's death and the on call manager in the home was notified at that time. The Ministry of Health (MOH) was not immediately notified of this as an unexpected death resulting from an accident until the ADOC left a telephone message with the MOH the following day. [O.Reg 79/10,s.107(1)2.]
7. The CI report indicates that immediate action to prevent recurrence is a planned re-evaluation of safety practices the following week regarding "the use of Sara lift by private care giver" There was no evidence of an investigation to conclude that this was the cause of the injury. [O.Reg 79/10,s.107(4)4.i]
Long term actions to correct the situation and prevent recurrence indicate that physio is to reassess the resident on return from hospital. There is no evidence that an investigation was completed to determine appropriate long term actions. [O.Reg 79/10, s.107(4)4.ii.]
8. The date and time of the incident resulting in an injury to an identified resident were incorrectly reported on the the CI Report. [O.Reg 79/10,s.107(4)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 all critical incidents are investigated and reported in accordance with the requirements of O.Reg. 79/10, s. 107, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following subsections:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. An identified individual hired by the home in July, 2011 in the capacity Registered Practical Nurse (RPN) was terminated from employment with the home in March, 2012 due to the individual's failure to provide a current certificate of registration with the College of Nurses of Ontario and the home's subsequent confirmation with the College of Nurses of Ontario that this individual did not have a valid licence to work as an RPN. There is no evidence that this employee provided a current certificate of registration with the College of Nurses of Ontario during the course of employment with the home in the capacity of RPN.[O.Reg 79/10,s.234(1)2.]
2. There is no evidence of a record of a Criminal Reference Check for an identified employee, as required under section 75(2) of the Act.
[O.Reg 79/10,s.234(1)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 to ensure that a record is kept for each staff member that includes a verification of the staff member's current certificate of registration with the College of Nurses of Ontario where applicable and the results of the staff member's criminal reference check required under subsection 75(2) of the Act, to be implemented voluntarily.

Issued on this 23rd day of March, 2012

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