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

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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
	2012_179103_0016	O-001170-12	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

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

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

his inspection was conducted on the following date(s): November 19, 20, 21, 2, 23, 26, 27, 2012

his inspection included the review of three critical incidents: log #O-001170-12, O-001470-12 and #O-002074-12.

uring the course of the inspection, the inspector(s) spoke with Personal upport workers (PSW's), Registered Nurses (RN's), Registered Practical Nurses RPN's), Food Services Manager, the Director of Care and the Administrator.

uring the course of the inspection, the inspector(s) completed a walk through f the home, observed resident care, nourishment pass, reviewed resident ealth care records, reviewed the home policy on abuse, lifts and transfers and taff work routines.

he following Inspection Protocols were used during this inspection:
utrition and Hydration

ersonal Support Services

revention of Abuse, Neglect and Retaliation

indings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
egend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 6 (7) whereby a resident was not transferred according to the resident plan of care.

Resident #1 has a cognitive impairment. On an identified date, two Personal Support Workers (PSW's) were transferring the resident from the bed to the wheelchair using a Sara lift. During the transfer, one PSW noted the resident had been incontinent and left the area to retrieve the needed supplies, leaving the resident in a standing position with one PSW. During the PSW's absence, the resident began to slide and was lowered to the ground by the remaining PSW. The resident sustained an injury.

According to Resident #1's plan of care, in effect at the time of the incident, the resident had partial weight bearing capabilities and was unsteady. The plan of care indicated Resident #1 required extensive assistance of two staff and the Sara Lift for all transfers.

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 resident transfers are done in accordance with the resident plan of care, 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. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 3 (1) 1, whereby a resident's right not to be neglected by the licensee or staff was not respected.

According to the LTCHA, 2007, s. 5, Neglect is defined as a failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #3 has a cognitive impairment and is incapable of activating a call bell or calling out for assistance.

On an identified date, two Personal Support Workers (PSW's) assisted the resident to the bathroom using a Sara lift. Approximately five hours later, two PSW's found Resident #3 in the bathroom, partially attached to the Sara lift sling and leaning to the left. A registered staff member was called to assess the resident and the resident was subsequently assisted back to bed. The resident was found to have reddened skin areas.

The PSW's working the evening shift on the identified date, failed to ensure the resident's safety in that he/she was left for an extended period of time on the toilet without the capability of calling for assistance.

The PSW's working the evening shift on the identified date, failed to complete rounds every two hours and failed to complete a final round of all assigned residents in accordance with Bay Ridges job description for Health Care Aides (HCA's)/PSW's working 1600-2230h.

The PSW assigned to the evening nourishment pass failed to ensure the resident was provided with a snack or fluids. The nourishment pass documentation record for the identified date, originally indicated the resident was given fluids, but was then corrected to reflect a refusal.

The Registered staff in charge of the home area on the night shift of the identified date, failed to complete hourly rounds to assess all residents for health and safety in accordance with Bay Ridges job description for RPN's/RN's working 2300-0700h.

The PSW's working the night shift on the identified date failed to complete an initial,

visual check of all residents following shift report in accordance with Bay Ridges job description for HCA's/PSW's working 2230-0630h.

As a result of the home's investigation into the allegations of resident neglect, seven staff members received disciplinary measures.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 8 (1) as required under O. Reg 79/10 s. 30 (1) 1, in that the required program for falls prevention and the relevant policies related to safe transfers were not complied with.

Resident #1 was assessed as requiring a Sara lift for all transfers. The home policy titled, "Use of Mechanical Lifts", LTC-P-70 indicates under "Procedure" that two staff members at a minimum must perform lifts and transfers from a lifting device.

On an identified date, staff failed to follow the home policy on lifts and transfers. Two staff did not perform the lift and transfer in its entirety which resulted in the resident sliding to the floor and sustaining a skin abrasion.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 20 (2).

The home policy on abuse, titled "Resident Non-Abuse", policy # LP-B-20 was reviewed. Under "Standard", the policy states, "all persons involved with Revera homes have a duty to report any form of alleged, potential, suspected or witnessed abuse, including suspected abuse outside of the home". The policy does not include an explanation of the duty to make mandatory reports, under LTCHA, 2007 s. 24 (1).

Additionally, under "Procedure", the policy states "if an alleged incident of abuse or neglect is found by the investigation process to be substantiated, the ED/designate will report to the applicable professional licensing bodies as mandated through jurisdictional legislated standards. The policy does not contain consequences for anyone that falls outside of a professional licensing body.

WN #5: 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 24 (1) whereby an incident of alleged neglect was not immediately reported to the Director.

The home submitted a critical incident advising an incident of alleged neglect occurred on an identified date and was submitted to the Director later that same day. Upon review of the identified resident's progress notes, the incident of neglect was identified on an earlier date than indicated by the critical incident. The home's case notes were reviewed and there is no indication the after hours pager was notified of the alleged neglect.

The Director of Care, Rosemarie Bynoe, confirmed the Director was not immediately informed of the alleged neglect.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 98 whereby the appropriate police force was not immediately notified of an alleged incident of neglect.

An alleged incident of neglect was identified on an identified date. The Director of Care, Rosemarie Bynoe, advised the alleged incident of resident neglect was not reported to the police until sometime later that afternoon.

ssued on this 30th day of November, 2012

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

Darlene Murphy