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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, Dec 7, 2017	2017_690130_0007	023935-17	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

GILLIAN HUNTER (130), AILEEN GRABA (682), KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 19, 23, 24, 25, 26 and 30, 2017.

During this inspection, clinical records, relevant policies and procedures, minutes of meetings and home's investigation files were reviewed, meal service and residents were observed.

The following complaint inspections were conducted concurrently with the RQI: 029227-16, 033594-16, 004045-17, 004047-17.

The following critical incident inspections were conducted during the RQI:- 033594-16, 002185-17.

The following onsite inquiries were conducted during the RQI: 018640-17, 020008-17, 003745-17, 001789-17, 001168-17. 008610-17, 012199-17, 018812-17, 018813-17, 023452-17, 011702-17, 022870-16,

Please refer to inspection report 2017_690130_0008, for information related to Complaint Inspections: 024632-17 and 024832-17, which were conducted concurrently with the RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Directors of Care (ADOC-1 and 2), Food Services Manager (FSM), Resident Assessment Instrument (RAI) Coordinator, Resident Services Coordinator, registered staff, personal support workers (PSW's), dietary staff, residents, families, President of Residents' Council, President of Family Council and Social Worker at Hamilton General Hospital.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend 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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A critical incident system report (CIS) submitted by the home 2017, involved resident #100 who had an unwitnessed fall which resulted in an injury requiring treatment.

Resident #100 was assessed as a high risk for falls in 2016. A review of the plan of care revealed specific fall prevention interventions were required.

An interview on in 2017 with staff #225 confirmed that fall prevention strategies included in the plan of care did not provide clear direction to the staff.

An interview with ADOC #500 in 2017 confirmed that resident #100's plan of care for fall prevention strategies failed to provide clear directions to staff and others who provide direct care to resident #100. [s. 6. (1) (c)]

Issued on this 7th day of December, 2017

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

Original report signed by the inspector.