Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2019	2019_560632_0023	016059-19	Critical Incident System

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

YULIYA FEDOTOVA (632)

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 3, 4, 8, 9, 10, 2019.

The following Critical Incident System (CIS) inspection was completed:
log #016059-19 - was related to falls prevention.

This inspection was completed concurrently with complaint inspection #2019_560632_0024:
log #013483-19 - was related medication and pain.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Resident Care (DOC), Assistant Director of Care #1 (ADOC), ADOC #2, Minimum Data Set (MDS) Residents Assessment Instrument (RAI) Co-ordinator, Physiotherapist (PT), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and their families.

During the course of the inspection, the inspector reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	Légende 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and revised at any other time when the resident's care needs changed.

Critical Incident System (CIS) Report (CI 2581-000017-19) submitted to the Ministry of Long-Term Care (MOLTC) related to a fall of resident#011, resulted in an injury, was reviewed.

During the inspection, it was observed that resident #001 performed identified activity independently. Review of resident #001 written plan of care indicated that resident #001 required identified assistance with a number of staff and was using specified assistive device, as needed. The most recent specified assessment indicated that the resident's identified status was to use specified assistive device with a number of staff. During the inspection, PT indicated that the resident was last assessed in August 2019 and was discharged from the specified program in September 2019. At that time, the resident used specified assistive device for specified activity and refused to perform some identified activities. PT indicated that registered staff in the unit was to complete the specified assessment if the resident's health condition changed, once the resident was discharged from specified program.

Review of the home's policy "Assessment for Lifts and Transfers" INDEX: CARE6-O10.03 indicated that as status of resident changed, each resident should be reassessed for mobility, transferring and lifting needs; when resident returned from hospital after an admission of 72 hours or longer, two S.A.L.T. team members would re-assess and document the resident's lift and transfer ability using the Assessment Form for Lifts and Transfers.

During the inspection, MDS RAI Co-ordinator confirmed that new interventions about performing identified activity for the resident with identified assistance with a number of staff or the use of specified assistive device were included into the resident's written care plan and KARDEX. During the inspection, the DOC acknowledged that there was no specified assessment conducted for the resident, once their specified status changed.

The home failed to ensure that resident #001's was reassessed and the plan of care reviewed and revised at any other time, when the resident's care needs changed. [s. 6. (10) (b)]

Issued on this 29th day of October, 2019

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

Original report signed by the inspector.