Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Feb 25, 2020	2020_679687_0001	023228-19, 024211-19	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

LOVIRIZA CALUZA (687), SHELLEY MURPHY (684)

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): February 19 to 21, 2020.

The following were inspected in this Critical Incident System (CIS) Inspection:

- One incident related to a resident fall which resulted in an injury.

- One incident related to an unsafe lift and transfer of a resident which resulted in an injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Environmental Support Manager (ESM), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, internal investigation notes and resident health care records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 had failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs had changed or care set out in the plan was no longer necessary.

The home submitted a Critical Incident (CI) report to the Director related to a fall in which the resident had sustained an injury on a specified date.

Inspector #684 observed resident #001’s room and observed a specified falls prevention intervention.

Inspector #684 reviewed resident #001’s electronic care plan in effect at that time which indicated a number of falls prevention interventions but failed to advise staff of the use of the specified intervention.

A review of the home's policy titled "Resident Assessment and Plan of Care", CARE1-P10, last reviewed April 30, 2019, Inspector #684 identified that, "The Interdisciplinary Team would ensure that the plan of care was accurate and reflective of resident's current status".

During separate interviews by Inspector #684 with Personal Support Worker (PSW) #106, Registered Practical Nurse (RPN) #105 and the Director of Care (DOC), they all indicated that resident #001 had a specified intervention as falls prevention intervention.

Inspector #684 reviewed the electronic care plan in effect at that time for resident #001 with PSW #106 and RPN #105. The staff members confirmed that the specified intervention was not identified in the resident’s care plan as a falls prevention intervention.

Inspector #684 reviewed resident #001's electronic care plan in effect at that time with the DOC, the DOC stated that resident #001’s specified falls prevention intervention was supposed to be noted in the electronic care plan but confirmed that it was not. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The home had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CI report to the Director on a specified date, which indicated that resident #002 had fallen while being transferred.

Inspector #687 reviewed resident #002's electronic progress notes on a specified date, which indicated that while the resident was being transferred from a specified area, the specified attachment was not properly attached which caused the resident to fall.

In a review of the home's policy titled "Assessment for Lifts and Transfer: Safe Resident Handling", last modified March 2019, it indicated that "Physical/Visual/Verbal risk assessment checks would be completed before all resident handling procedures to ensure the task was safe to complete."

In an interview conducted by Inspector #687 with resident #002, they stated that on a specified date, PSW #102 and #104 were transferring them from a specified area when the specified attachment slid-out of the specified equipment which caused the resident to fall.

During an interview conducted by Inspector #687 with PSW #102, they stated they were assisting resident #002 with PSW #104 on a specified date. The PSW further stated that they were transferring resident #002 from a specified area using a specified equipment when PSW #104 observed that the specified attachment came off and the resident was observed sliding onto the floor.

In an interview with RPN #103, they stated that they interviewed PSW #102 and #104 and asked them what prompted the fall incident of resident #002 on a specified date. The RPN stated that both PSWs stated that the specified attachment slid-out from the specified equipment which was defective. The RPN checked the specified attachments

but no defect was identified.

During an interview conducted by the Environmental Support Manager (ESM), they stated that they were made aware of the fall incident of resident #002 on a specified date. The ESM stated that they were in contact with the equipment representative to determine the status of the identified equipment and attachment. The ESM further stated that the equipment representative assessed the identified equipment and attachment but no defect was found on both. [s. 36.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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. The licensee had failed to 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 were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified.

The home submitted a CI report to the Director related to a fall incident in which resident #001 had sustained an injury on a specified date.

Inspector #684 reviewed resident #001's electronic progress notes and identified the following documentation on a specified date which provided details of the conversation with the enacted SDM for not being notified. The Inspector further identified a documentation in the electronic progress notes which indicated that on a specified date and time, the resident was sent to a specified facility.

Inspector #684 reviewed the home's policy titled "Fall Prevention and Injury Reduction Post Fall Management", CARE5-010.05, last reviewed March 31, 2019, which stated, "The following additional communication and documentation was required: For those residents who have an enacted SDM, the SDM would be notified".

During an interview by Inspector #684 with the DOC, the DOC stated, "Family was made aware of resident #001's fall when it occurred but was not made aware that the resident was sent to a specified facility due to a change in condition".

Inspector #684 interviewed the Executive Director (ED) regarding notification of the enacted SDMs when there was a change in the resident's condition. The ED stated that their expectation from their staff was that the enacted SDM would be notified of the resident's change in condition. [s. 107. (5)]

Issued on this 25th day of February, 2020

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

Original report signed by the inspector.