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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Apr 7, 2014	2014_247508_0010	H-000336-13/H-000230-13	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

BAYWOODS PLACE
330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 11, March 13, 2014

This complaint inspection was conducted concurrently with complaint inspection #2014_247508_009

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Resident Assessment Instrument (RAI)Co-ordinator, Personal Support Workers(PSW), registered staff and residents

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed relevant policies and procedures, observed provisions of care

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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.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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family

and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents rights were fully respected and promoted and protected from abuse.

A)Resident #001 was identified as having responsive behaviours. On an unidentified date in 2013, resident #005 was discovered exiting resident #001's room, crying. The clinical records state that it was understood that the resident had been struck by resident #001. Resident #001 confirmed that resident #005 had been hit because it was resident #001's perception that the resident was stealing resident #001's stuff. Resident #001 had previous incidents of aggression towards co-residents including an incident that occurred earlier in 2013, when a co-resident wandered into resident #001's room.
Both incidents occurred when co-residents wandered into resident #001's room. Interventions to minimize resident #001's responsive behaviours, triggered by co-residents wandering into the resident's room were not developed or implemented until several weeks later in 2013.

B)On an unidentified date later in 2013, resident #001 had another physical altercation. According to the clinical records, after the incident, the registered staff was directed to check medication to decrease the residents agitation. Resident #001 had medications ordered for agitation which had been previously administered to the resident to decrease responsive behaviours. According to the documentation, each time the medication was administered for agitation or restlessness it was effective. The medication was not administered to resident #001 after this incident of physical aggression.
Resident #001 had another physical altercation later the same day. [s. 3. (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 be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the staff and the others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Previously issued as a VPC - 10/25/2012

Resident #001 was identified as having responsive behaviours that included physical altercations with staff and co-residents. The Behavioural Support of Ontario (BSO) staff were involved with resident #001 to assist staff at the home in managing the resident's responsive behaviours.

The BSO identified triggers of resident #001's responsive behaviours and developed interventions for the home's staff to implement on an unidentified date in, 2013. The home maintained documentation of the BSO notes which included this information, however did not include this in the resident's plan of care. It was confirmed by the Director of Care (DOC) that the home's staff refer to the resident's care plan for directions in providing care to residents.

A care conference was held on an unidentified date in 2013, with the home's multidisciplinary team and family members who were also the Substitute Decision Makers (SDM) for resident #001. According to resident #001's plan of care, the resident's family were to provide input to assist staff in managing the resident's responsive behaviours. A review of the clinical records indicates that during the care conference, the home's staff did not discuss any concerns or issues related to resident #001's responsive behaviours. It was confirmed by the SDM's that the home did not discuss issues related to resident #001's responsive behaviours, or the potential for discharge.

Resident #001 was discharged from the home shortly after the care conference, after two incidents of responsive behaviours occurred involving resident #001. According to the clinical records, the home discharged resident #001 without any discussions with the resident's family. [s. 6. (4) (a)]

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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

s. 148. (3) Before discharging a resident from the home under clause 145 (3) (a), (b) or (d), the licensee shall offer to,
(a) assist the resident in planning for discharge by identifying alternative accommodation, health service organizations and other resources in the community; and O. Reg. 79/10, s. 148 (3).
(b) contact appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources. O. Reg. 79/10, s. 148 (3).

Findings/Faits saillants :

1. The licensee did not ensure that before resident #001 was discharged, notice of the discharge was given to the resident's substitute decision-maker, as far in advance of the discharge as possible.

On an unidentified in 2013, resident #001 had two physical altercations. The staff did not provide the resident with the medication intervention that was ordered for responsive behaviours. Resident #001 was transferred to hospital for an assessment. Later that evening, the hospital called to report to the home that they would be transferring resident #001 back to the home. The home indicated at that time that they would not be accepting the resident back.

On an unidentified date in 2013, the home completed a discharge order for resident #001, indicating they were not able to manage the resident's responsive behaviours. The home did not discuss the resident's discharge or the potential for a discharge at any time with the SDM's until the day of discharge. [s. 148. (1) (b)]

2. The licensee did not ensure that before discharging resident #001, they considered alternatives to discharge, collaborated with the appropriate placement co-ordinator and other health service organizations, kept the substitute decision-makers informed, giving them an opportunity to participate in the discharge planning with their wishes taken into consideration, or provide written notification to the resident's substitute decision-makers,setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

On an unidentified date in 2013, an annual care conference was held with the SDM's and the multidisciplinary team of the home to review resident #001's care and discuss any issues or concerns. A review of the resident's clinical records indicate that during the resident's care conference, there were no concerns or issues discussed regarding resident #001's responsive behaviours or previous incidents of physical aggression towards staff and co-residents, which subsequently led to resident #001's transfer to hospital and discharge from the home in 2013.

After the care conference, on an unidentified date in 2013, resident #001 had two physical altercations and was transferred to hospital for an assessment. Later that evening, the hospital called to report to the home that they would be transferring resident #001 back to the home. The home indicated that they would not be accepting the resident back. The following day, the home discharged resident #001, indicating

they were not able to manage the resident's responsive behaviours. The home did not discuss the residents discharge or the potential for a discharge at any time with the SDM's until the day of discharge in 2013. [s. 148. (2)]

3. The licensee did not offer to assist the substitute decision-makers in planning for discharge by identifying alternative accommodation, health service organizations or other resources in the community, and did not assist with contacting the appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources.

On an unidentified date in 2013, resident #001 had two physical altercations and was transferred to hospital for an assessment. Later that evening, the hospital called to report to the home that they would be transferring resident #001 back to the home. The home indicated at that time that they would not be accepting the resident back.

The following day, the home completed a discharge order for resident #001, indicating they were not able to manage the resident's responsive behaviours. The home did not offer to assist the substitute decision-makers in the planning of the discharge, or provide contact information of appropriate health organizations or other resources in the community. The home did not discuss the residents discharge or the potential for a discharge at any time with the SDM's until the day of discharge. [s. 148. (3)]

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 be implemented voluntarily.

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Issued on this 8th day of April, 2014

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