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
May 6, 2014	2014_232112_0009	L-000316-14	Critical Incident System

Licensee/Titulaire de permis

~~REVERA LONG TERM CARE INC.~~ RESPONSIVE MANAGEMENT.
~~55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2~~

Long-Term Care Home/Foyer de soins de longue durée

~~ROSE GARDEN VILLA~~ BERKSHIRE CENTRE
350 DOUGALL AVENUE, WINDSOR, ON, N9A-4P4

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

CAROLE ALEXANDER (112)

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): March 26 & April 23, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Restorative Care Coordinator, a Personal Support Worker and a Family Member

During the course of the inspection, the inspector(s) reviewed a critical incident, the home's internal investigation, a clinical record and policies and procedures for
Infection Control, Lifts and Transfer and the Prevention of Abuse and Neglect

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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 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 Licensee did not ensure that staff used safe transferring and positioning devices &/or techniques when assisting a resident during a transfer.
2 staff were observed assisting a resident using a sit to stand lift which was unsafe for the residents transferring needs.
This was confirmed by the resident's most recent transfer assessment and care planning needs in the resident's clinical record and the Administrator [s. 36.]

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 for ensuring that staff use safe transferring and positioning devices when assisting residents, 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:
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).

Findings/Faits saillants :

1. The Licensee did not ensure that resident's right for privacy was always maintained for 2 Residents
On 3 occasions staff were observed to provide personal care for incontinence and not using privacy curtain.
This was confirmed by the Administrator [s. 3. (1) 8.]

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 did not ensure that the following home policies were complied with by staff:

1. "Safety in Ambulating Lifting and Transferring Program" dated June 2012 states that "Two staff will always be present during the operation of a mechanical lift" Two staff were not present during the operation of a lift on the following dates: February 10, 11, 13, 16, 17, 18, 20 and March 15, 16, 2014
2. Infection Control "Routine Practices & Additional Precautions" dated April 2013 states
"Do not double glove" "Do not use the same pair of gloves for more than one resident" "All staff will perform hand hygiene at point of care"
On February 11, 2014 a staff member is observed to use a kleenex for her nose and did not wash her hands prior to making contact with a resident.
Another staff member is observed using a resident's bedside table to place the garbage receptacle.
On March 09, 2014 (2 separate occasions) and March 16, 2014 a staff member is observed making contact with a resident's call bell and proceeding to another resident and did not practice hand hygiene
On March 15, 2014 a staff member is observed "double gloving"

This was confirmed by the Administrator. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

1. A resident was not provided with care as set out in the resident's plan of care
The plan of care states that resident #0011 requires a Maxi Lift for transfers. On February 07, 2014 two staff were observed transferring the resident using a sit to stand lift.
This was confirmed by the Administrator [s. 24. (6)]

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Issued on this 6th day of May, 2014

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

C. ALEXANDER