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
Jun 24, 2013	2013_224122_0003	S-000091-13	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

PINEWOOD COURT
2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5

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

ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 15 - 17, 2013

The purpose of this inspection was to conduct a complaint inspection in regards to Log S-000091-13

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered and non-registered staff, residents and family members.

During the course of the inspection, the inspector(s) observed the provision of care and services to residents of the home,reviewed resident health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Infection Prevention and Control

Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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. Resident #300 reported that they were dissatisfied with receiving only one bath per week and stated that their scheduled bath day was either a Friday or Saturday. Three staff members were interviewed over the course of the inspection and reported that residents' scheduled bath days were identified in their respective plans of care and the PSW electronic kardex, also known as a task list. The Inspector reviewed resident #300's plan of care and electronic kardex but was unable to find directions which identified the resident's scheduled bath days. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. s. 6 (1) c [s. 6. (1) (c)]

2. Staff #1004 reported that directions pertaining to colostomy care are contained in the residents' respective electronic treatment records for RPNs to follow. Staff #2004 reported that directions for colostomy care are located on the electronic treatment record and added that a printed copy of the electronic treatment record is contained in the PSW binder for their reference regarding colostomy care. The Inspector reviewed resident #200's electronic treatment record and found no directions pertaining to colostomy care.

The Inspector located a care plan related to colostomy care for resident #200; however, the PSW electronic Kardex, did not contain the same detailed directions outlined in the resident's care plan.

The Plan of Care for resident #200 includes the electronic treatment record; the printed copy of the electronic treatment record contained in a binder; the care plan document and electronic Kardex. The licensee failed to ensure that plan of care set out clear directions to staff and others who provide direct care to the resident. s. 6 (1) c [s. 6. (1) (c)]

3. The plan of care for resident #100 identifies a preference not to be toileted; as toileting causes resident #100 distress, anxiety and bladder incontinence. The PSW electronic kardex, also known as a task list, identifies that resident #100 should be toileted every shift. Staff #2003 was interviewed by the Inspector and reported that resident #100 is not toileted. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. s. 6 (1) c [s. 6. (1) (c)]

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 with LTCHA 2007, S.O. 2007, c. 8, s. 6 (1), to ensure that the plans of care for residents #100, #200 and #300 set out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

Issued on this 24th day of June, 2013

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