



**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
prévus le Loi de 2007 les
foyers de soins de longue**

**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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 16, 17, 18, 19, Feb 3, 11, Mar 14, 15, 16, 2012	2012_051106_0002	Critical Incident

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

BIRCHWOOD TERRACE
237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Quality and Staff Education Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal support Workers (PSW), Substitute Decision-Makers (SDM) and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On January 17, 2012 during the initial walk-through of the home inspector 106 asked a RN where the strong urine odour was coming from and they indicated a resident's room. On January 17, 18, and 19, 2012, inspector 106 noted a very strong lingering urine odour in and around the same room. The licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. [O. Reg. 79/10, s. 87 (2) (d)] (106)

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 ensure that procedures are developed and implemented for, addressing incidents of lingering offensive odours, 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 subsections:

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.

2. Every resident has the right to be protected from abuse.

3. Every resident has the right not to be neglected by the licensee or staff.

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.

5. Every resident has the right to live in a safe and clean environment.

6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

9. Every resident has the right to have his or her participation in decision-making respected.

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.

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.

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.

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.

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.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

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.

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.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

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.

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.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

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.

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. On January 17, 2012, at 1343 hours, inspector 106 observed the call bell for a resident, was ringing. A staff person was observed by inspector 106 talking to the resident, who was in their doorway. The staff member was overheard to tell the resident, someone would be along to help them. This same staff person was observed to enter the resident's room and when the staff person came out the call bell was no longer ringing. At 1347 hours, an activity staff person came to the unit and asked the RPN if someone had assisted the resident to the washroom, as they wanted to go to the Bingo. At 1350 hours a PSW assisted the resident to the washroom. At 1349 hrs, inspector 106 asked the activity staff person how long the resident had been waiting for assistance and staff person stated about 20 minutes. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent their needs, was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 4] (106)

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program
Specifically failed to comply with the following subsections:**

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. January 18 and 19, 2012, a resident was observed by inspector 106 walking on the unit in bare feet, they were also noted to have a dressing on their left foot. On January 18, 2012, inspector 106 approached 2 RPNs informed them that the resident was not wearing footwear. Neither RPN attempted to find footwear for the resident or direct any of the PSWs on the unit to find and put footwear on the resident. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program. [O. Reg. 79/10, s. 229 (4)] (106)

WN #4: 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 subsections:

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
(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).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The most recent RAI MDS assessment for a resident, completed December 11, 2011, under section G, indicates that they walk in room and corridors with limited assistance of one staff person and requires one person physical assist to transfer. The written plan of care for this resident indicates, "1:1 supervision with transfer belt" and resident "frequently ambulates unassisted and unsupervised r/t their cognitive impairment. Remind to ask staff for necessary assistance." A PSW, told inspector 106 that the resident transfers with a sit to stand lift and requires two persons to assist and the resident is currently not ambulating but using a wheelchair full time post surgery. The licensee 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 change or care set out in the plan is no longer necessary. [LTCHA, 2007 S. O. 2007, c. 8, s. 6 (10) (b)] (106)
2. The written plan of care for a resident under the section titled transfers, indicates they are to be transferred "1:1 supervision with transfer belt". The most recent "Assessment Form for Lifts and Transfers" dated January 17, 2012, indicates that they are to be transferred with a mechanical sit-stand lift. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (4) (a)] (106)

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. On January 17, 2011 at 1325hrs, inspector 106 observed the call bell in a resident's room hanging against the wall and was not accessible to the resident who was lying in bed. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is easily be seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

- 1. Customary routines.**
- 2. Cognition ability.**
- 3. Communication abilities, including hearing and language.**
- 4. Vision.**
- 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.**
- 6. Psychological well-being.**
- 7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.**
- 8. Continence, including bladder and bowel elimination.**
- 9. Disease diagnosis.**
- 10. Health conditions, including allergies, pain, risk of falls and other special needs.**
- 11. Seasonal risk relating to hot weather.**
- 12. Dental and oral status, including oral hygiene.**
- 13. Nutritional status, including height, weight and any risks relating to nutrition care.**
- 14. Hydration status and any risks relating to hydration.**
- 15. Skin condition, including altered skin integrity and foot conditions.**
- 16. Activity patterns and pursuits.**
- 17. Drugs and treatments.**
- 18. Special treatments and interventions.**
- 19. Safety risks.**
- 20. Nausea and vomiting.**
- 21. Sleep patterns and preferences.**
- 22. Cultural, spiritual and religious preferences and age-related needs and preferences.**
- 23. Potential for discharge. O. Reg. 79/10, s. 26 (3).**

Findings/Faits saillants :

1. The most recent RAI MDS assessment for a resident, was completed December 11, 2011, under section G, indicates that they walk in room and corridors with limited assistance of one staff person and requires one person physical assist to transfer. No interdisciplinary assessments with respect to the resident's physical functioning was found after the resident sustained a fall on December 28, 2011 or when they returned to the home on January 11, 2012 post surgery. The resident's written plan of care under the section titled "mobility" indicates, "supervision 1:1 with transfer belt assistance. unable to use walker r/t #". The resident was observed by inspector 106 to only use a wheelchair during this inspection. A PSW told inspector 106 that the resident is currently not ambulating but using a wheelchair full time post surgery. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs. [O. Reg. 79/10, s. 26 (3) 10)] (106)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. On January 18, 2012, inspector 106 reviewed multiple daily documentation records for the current month. It was found that multiple residents did not receive 2 baths per week. There is no bath documented for a resident from January 1 to January 17, 2012 and another resident is only documented to have had 2 baths from January 1 to January 17, 2012. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [O. Reg. 79/10, s. 33 (1)] (106)
2. On January 17, 2012 at approximately 1356 hours, a PSW approached inspector 106 with concerns that the residents were not receiving their baths due to staffing shortages. They stated that since the summer the residents routinely do not get their baths due to the staff working short. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [O. Reg. 79/10, s. 33 (1)] (106)

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 ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 20th day of March, 2012

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

