Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSE-MARIE FARWELL (122)
Inspection No. / No de l'inspection :	2012_053122_0001
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jan 23, 24, 25, 26, 27, Feb 21, 24, 2012
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 55 Standish Court, 8th Floor, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	THUNDER BAY INTERIM LONG-TERM CARE CENTRE 445 SOUTH JAMES STREET, THUNDER BAY, ON, P7E-2V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JULIANA JASON

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)]

Grounds / Motifs :

1. The Inspector reviewed a resident's health care record on January 24, 2012 and noted that only one bath per week was recorded for the weeks of December 22, 2011, January 5, 2012 and January 12, 2012. The Inspector reviewed the resident's plan of care which identified that the resident will be bathed on Wednesdays and Saturdays. The resident was interviewed by the Inspector on January 25, 2012 and reported that they had not consistently received two baths per week due to staff shortages. 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)] (122)
2. A PSW was interviewed by the Inspector on January 25, 2012. The PSW identified that they work every second weekend and reported there have been occasions when staff sick calls have not been back filled. The PSW added that during these times, resident care takes longer and on occasion residents have missed their bath as a result. 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)] (122)
3. A RPN was interviewed by the Inspector on January 25, 2012. The RPN identified that they work every second weekend and reported that there is frequently a shortage of staff on weekends when sick calls were not back filled. The RPN added that residents occasionally miss their baths as a result. 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)] (122)
4. The Inspector reviewed a resident's health care record on January 24, 2012 and noted that only one bath was documented for the week of December 29, 2011. The Inspector reviewed the resident's plan of care which identified that the resident will be bathed on Tuesdays and Saturdays. The resident was interviewed on January 24, 2012 and reported that they usually receive two baths per week but in recent weeks they had missed their Saturday bath because "they didn't have enough staff". 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)] (122)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 21, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:
Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1 Fax: (416) 327-7603

by fax upon:

after the day of mailing and when service is made by fax, it is ensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of February, 2012

Signature of Inspector / Signature de l'inspecteur : R. Farwell

Name of Inspector / Nom de l'inspecteur : ROSE-MARIE FARWELL

Service Area Office / Bureau régional de services : Sudbury Service Area Office

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 23, 24, 25, 26, 27, Feb 21, 24, 2012	2012_053122_0001	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

THUNDER BAY INTERIM LONG-TERM CARE CENTRE
445 SOUTH JAMES STREET, THUNDER BAY, ON, P7E-2V6

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.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, the Cook, the Physiotherapy Aide, Registered Staff, PSWs, residents of the home.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

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 VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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. The Inspector reviewed a resident's health care record on January 24, 2012 and noted that only one bath was documented for the week of December 29, 2011. The Inspector reviewed the resident's plan of care which identified that the resident will be bathed on Tuesdays and Saturdays. The resident was interviewed on January 24, 2012 and reported that they usually receive two baths per week but in recent weeks they had missed their Saturday bath because "they didn't have enough staff". 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)]
2. The Inspector reviewed a resident's health care record on January 24, 2012 and noted that only one bath per week was recorded for the weeks of December 22, 2011, January 5, 2012 and January 12, 2012. The Inspector reviewed the resident's plan of care which identified that the resident will be bathed on Wednesdays and Saturdays. The resident was interviewed by the Inspector on January 25, 2012 and reported that they had not consistently received two baths per week due to staff shortages. 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)]
3. A PSW was interviewed by the Inspector on January 25, 2012. The PSW identified that they work every second weekend and reported there have been occasions when staff sick calls have not been back filled. The PSW added that during these times, resident care takes longer and on occasion residents have missed their bath as a result. 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)]
4. A RPN was interviewed by the Inspector on January 25, 2012. The RPN identified that they work every second weekend and reported that there is frequently a shortage of staff on weekends when sick calls were not back filled. The RPN added that residents occasionally miss their baths as a result. 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. [LTCHA 2007, O. Reg. 79/10, s. 33 (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. The Inspector conducted a walkthrough of the home on January 23, 2012 and observed an infection control cart containing personal protective equipment located outside of a resident's room. The Inspector did not observe contact precautions signage posted in the immediate vicinity of the cart. The RN was interviewed by the Inspector on January 23, 2012 and identified that contact precautions were required to provide direct care to the resident who resided in the room. The Inspector reviewed the licensee's Infection Control Policy and noted that the policy states "Signage indicating the required contact precautions should be posted at the entrance to a resident's room." The licensee failed to ensure that all staff participate in the implementation of the program. [LTCHA 2007, O. Reg. 79/10, s. 229 (4)]

2. The Inspector conducted a walkthrough of the home on January 23, 2012 and observed an infection control cart containing personal protective equipment located outside of a resident's room. The Inspector did not observe contact precautions signage posted in the immediate vicinity of the cart. A PSW was interviewed by the Inspector on January 23, 2012 and identified that contact precautions were required when providing direct care to the resident who resided in the room. The Inspector reviewed the licensee's Infection Control Policy and noted that the policy states "Signage indicating the required contact precautions should be posted at the entrance to a resident's room." The licensee failed to ensure that all staff participates in the implementation of the program. [LTCHA 2007, O. Reg. 79/10, s. 229 (4)]

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, O. Reg. 79/10, s. 229 (4) to ensure that all staff participate in the implementation of the infection control program, to be implemented voluntarily.

WN #3: 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. (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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The Inspector reviewed a resident's plan of care completed on December 28, 2011 and noted that the plan of care did not identify the need for contact precautions when providing direct care to the resident nor provide any direction regarding the use of personal protective equipment. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O., c. 8, s. 6 (1) c]
2. On January 24, 2012 the Inspector attempted to locate the printed care plans for two residents of the home who shared a room but found two other residents' care plans located under the respective room tab in the binder. A PSW was interviewed and reported that the current residents of the room had recently moved into the room together and had previously resided in separate rooms on other home areas. The Inspector searched all care plan binders for all home areas a second time but again was unsuccessful in locating the residents' printed care plans. The Acting Director of Care (DOC) was interviewed by the Inspector on January 24, 2012 and reported that the PSWs have access to printed copies of resident care plans stored in binders at the nursing station but do not have access to electronic documentation. The licensee failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.[LTCHA 2007, S.O. 2007, c. 8, s. 6 (8)]

Issued on this 12th day of March, 2012

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