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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 2, 2017	2017_650565_0004	018798-16, 026452-16, 028399-16, 034286-16, 001550-17, 002762-17, 003528-17, 004039-17, 004414-17, 004548-17, 006457-17	Critical Incident System

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

ELGINWOOD
182 YORKLAND STREET RICHMOND HILL ON L4S 2M9

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

MATTHEW CHIU (565), CECILIA FULTON (618), JOY IERACI (665), SHIHANA RUMZI (604)

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 29, 30, 31, April 3, 4, 5, and 6, 2017.

During the course of the inspection, the following Critical Incident Intakes were inspected:
- 018798-16: related to resident to resident abuse
- 026452-16, 001550-17: related to resident fall with injury
- 034286-16, 002762-17, 003528-17, 004548-17: related to staff to resident abuse
- 004039-17: related to Residents' Bill of Rights
- 004414-17: related to resident injury with unknown cause
- 006457-17: related to staff to resident neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Food Services Manager, Environmental Services Manager, Resident Services Coordinator, Nursing Administrator, Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), Director, related to staff to resident abuse. The CIS report indicated a family member of resident #032 requested Personal Support Worker (PSW) #127 to provide a specified care to the resident. PSW #127 asked the resident taking an identified inappropriate intervention as the PSW had other residents to look after. The concern was reported to the Resident Services Coordinator (RSC) by the family member.

An interview with resident #032 stated he/she needed the specified care and his/her family member approached PSW #127 and requested assistance. Resident #032 further stated that the PSW told him/her to take the above mentioned inappropriate intervention. The resident indicated he/she does not like it. The resident further indicated that the incident made him/her feel bad as he/she is in the long term care home to receive assistance and was told to take the inappropriate intervention.

An interview with the family member of resident #032 indicated that he/she requested the

specified care for the resident. The PSW that regularly cares for the resident voiced the inappropriate intervention to the resident and the family member. The family member reported the incident to the RSC.

An interview with PSW #127 acknowledged that he/she did ask resident #032 and the family member in the resident's room to take the inappropriate intervention. The PSW indicated he/she did not want the resident to do the specified care on his/her own in case he/she falls. The PSW indicated that resident #032's dignity was not respected according to the Resident's Bill of Rights.

An interview with the RSC, indicated resident #032's family member reported a concern to him/her on an identified date. The family member indicated that he/she requested PSW #127 to provide the specified care for resident #032. PSW #127 voiced to resident #032 and the family member to take the inappropriate intervention for the resident. The RSC informed the Director of Care (DOC) of the concern to follow up. The RSC indicated that the incident did not respect resident's #032's dignity according to the Resident's Bill of Rights.

An interview with the DOC indicated he/she knows about the above incident as the RSC provided him/her with a "Client Service Response" form which is completed when a complaint is brought to the home. The DOC indicated PSW #127 acknowledged telling resident #032 to take the inappropriate intervention as the PSW was concerned that resident will do the specified care without assistance and be at risk for falls. The DOC indicated the incident above did not respect resident #032's dignity according to the Residents' Bill of Rights. [s. 3. (1) 1.]

2. The home submitted a CIS report to the MOHLTC, Director, related to staff to resident abuse. The CIS report indicated resident #031 was afraid of PSW #122 after an incident happened during a specified care for resident #031. Resident #031 indicated PSW #122 acted in an identified manner during the care, and the resident was very upset of the incident. The incident was reported to Registered Practical Nurse (RPN) #126 by resident #031 on an identified date and time.

An interview with resident #031 indicated the incident occurred during an identified time period. Resident #031 indicated PSW #122 acted and verbally communicated to him/her in the identified manner when an identified event happened during the specified care. The resident further stated it made him/her feel upset and he/she reported the incident to RPN #126 on the identified date. The resident also stated whenever he/she sees the

same PSW in the unit or hears the PSW's voice, he/she becomes afraid.

An interview with resident #031's Substitute Decision Maker (SDM) indicated resident #031 informed him/her of the above mentioned incident and the identified manner that PSW #122 acted during the care. The SDM further stated the resident indicated that the actions of PSW #122 were intimidating.

An interview with RPN #126 indicated that on the identified date, he/she observed resident #031 upset in an identified home area with an identified person. The RPN stated the resident told him/her that the resident was afraid of PSW #122 and was upset after the above mentioned incident during the specified care. The resident told the RPN that PSW #122 verbally communicated to him/her in the identified manner during the care. The RPN informed the resident that he/she would inform management of the incident. The RPN stated he/she reported the incident to the DOC three days later. The RPN stated he/she documented the conversation in a progress note and acknowledged that the resident's right to be treated with courtesy and respect had not been fully promoted by PSW #122.

An interview with PSW #122 stated he/she is able to recall the incident with resident #031 during the specified care. The PSW denied interacting with the resident in the identified manner and did not see a reason as to why the resident would be uncomfortable with him/her. The PSW stated the DOC spoke to him/her about the incident and an identified action was taken in response to the incident.

The DOC indicated three days after the incident, he/she read RPN #126's progress notes and became aware of incident. The DOC stated the incident with resident #031 was not communicated to him/her by the RPN on the day that it happened. When the DOC interviewed resident #031, the resident was fearful of PSW #122 and expressed a specified concern with the PSW. The DOC indicated the staff in the home are expected to treat residents with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity according to the Residents' Bill of Rights. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the resident had the right to meet privately with his or her spouse or another person in a room that assures privacy.

The home submitted a CIS report to the MOHLTC, Director, indicating an identified PSW who was conducting a specified care for a resident had taken a video with his/her cell

phone of an identified interaction between two residents in a resident's room. The identified PSW shared the video with another identified PSW who indicated to the first PSW that he/she violated the resident's rights by taking the video. The second identified PSW then reported the incident to the nurse.

A review of resident #021 and #022's plan of care indicated family is aware and agreeable to the identified interaction between these residents, and staff is to provide privacy. The plan of care identified that consent had been obtained from both resident's families which the inspector had reviewed.

An interview with PSW #125 indicated that the first identified PSW showed him/her a video of the identified interaction between resident #021 and #022 on his/her cell phone. PSW #125 indicated he/she told the PSW to delete the video as it was invading the resident's privacy and then reported the incident to RPN #124. The PSW added that the staff on the floor were aware of the identified interaction between the residents and is to provide privacy to the residents. PSW #125 indicated that the PSW videotaping the residents was against the resident's rights and the privacy of the two residents had not been respected.

Interview with RPN #124 stated the home is aware of the identified interaction between resident #021 and #022, and families are agreeable for this. The RPN stated PSW #125 reported the above incident to him/her. The RPN spoke with the first identified PSW and confirmed he/she took a video of the identified interaction between resident #021 and #022 in an identified room. The RPN stated the PSW invaded the two residents' rights and privacy specially taking the video of the identified interaction between the residents.

An interview with the Staff Relief Nursing Administrator (NA), indicated he/she was made aware of the above incident from the home. The NA indicated the PSW acknowledged that he/she used his/her cell phone and attempted to take pictures of the identified interaction between the two residents but the pictures were not saved. The NA stated the PSW violated the Residents' Bill of Rights to privacy and an identified policy and code of conduct, and a specified action was taken.

An interview with the DOC and the RSC acknowledged the PSW videotaped the identified interaction between resident #021 and #022 in the identified room. The DOC and the RSC indicated the home conducted their investigation and spoke to the NA. The DOC was aware of the specified action that stated by the NA. The DOC and the RSC indicated they constituted this incident to be violated the residents' privacy. [s. 3. (1) 21.]

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 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
- meet privately with his or her spouse or another person in a room that assures privacy, 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. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Review of a CIS report and progress notes revealed resident #001 fell on an identified date, in an identified home area. The resident was sent to hospital on the same day and

diagnosed with a specified significant injury.

Review of the resident's plan of care revealed the resident had both cognitive and physical impairments and was at risk for fall.

On an identified date, the inspector observed the resident to be sitting on a wheelchair with an identified fall prevention device in place for the resident. Further review of the resident's fall prevention written plan of care did not indicate the use of the identified fall prevention device for the resident.

Interviews with PSW #111 and Registered Nurse (RN) #112 indicated the resident required a specified transferring assistance and had an identified contributing factor for the resident's risk for falls. The identified fall prevention device was used to alert staff members for resident's falls prevention care needs. The staff members indicated the use of the device was started after the resident had the above mentioned significant injury and started demonstrating the contributing factor for risk for falls.

PSW #111 indicated he/she had access to the plan of care and was aware that the use of the identified fall prevention device was not stated in the written plan of care. Interviews with RN #112 and the DOC confirmed that the written plan of care did not set out the use of the identified fall prevention device for the resident. [s. 6. (1) (a)]

2. 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, the care set out in the plan has not been effective.

Review of a CIS report and progress notes revealed resident #001 fell on an identified date, in an identified home area. The resident was sent to hospital on the same day and diagnosed with a significant injury.

Review of the resident's plan of care revealed the resident had both cognitive and physical impairments and was at risk for fall. The resident's history for falls revealed he/she had seven identified falls within an identified time period prior to the above mentioned fall incident.

Review of resident's fall prevention plan of care for during the first of the seven identified falls revealed that the goal was to have the resident remain free from falls until next review date, and it directed staff to perform two identified interventions.

Further review of the fall prevention plan of care during the seven identified falls did not reveal any further interventions.

Interviews with PSW #113, RN #112, and the Physiotherapist (PT) indicated the resident was at risk for falls due to impaired cognition and physical function. The staff members stated the plan had been ineffective to prevent the resident from falling and confirmed that the resident had multiple falls during this time period. The staff members confirmed the falls prevention plan of care had not been revised after these seven falls.

Interview with the DOC confirmed the home's expectation is that any resident be reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective. The DOC further confirmed that resident #001's fall prevention plan of care was not revised after the above mentioned seven falls. [s. 6. (10) (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 to ensure that:
- there is a written plan of care for each resident that sets out the planned care for the resident, and
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's equipment was maintained in a safe condition and in a good state of repair.

Review of a CIS report and progress notes revealed resident #002 fell on an identified date. The resident was found sitting on the floor in an identified home area. The resident was sent to hospital on the same day and diagnosed with a significant injury.

Review of resident #002's plan of care revealed the resident had cognitive and physical impairments and was at risk for fall. The resident had an identified falls prevention equipment being used as one of the falls prevention interventions.

Further review of the progress notes revealed that at the time of the above mentioned fall the resident's identified falls prevention equipment was not functional and observed to be broken.

Interview with PSW #113 indicated the resident was at risk for fall and that the resident required the use of the identified falls prevention equipment for resident's fall prevention needs. Interview with RN #115 indicated that the resident was sleeping prior to his/her fall. RN #115 further indicated that the resident was found sitting on the floor in the identified home area, and the identified falls prevention equipment was not functional to alert staff. The staff member confirmed that after the fall, he/she observed the edge of the falls prevention equipment was crushed and it was broken.

Interview with the DOC confirmed that the identified falls prevention equipment used for resident #002 was not in a good state during the above mentioned fall incident. [s. 15. (2) (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 to ensure that the home's equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Review of a CIS report and progress notes revealed on an identified date, resident #003 and #004 had an identified interaction and as a result resident #004 fell. Resident #004 was sent to hospital on the next day and diagnosed with a significant injury.

Review of resident #003 and #004's plan of care revealed both residents had physical and cognitive impairments. Resident #003 had demonstrated identified responsive behaviours, and he/she had a specified care for his/her behaviours when the above mentioned incident happened.

Interview with PSW #122 indicated that on the identified date, resident #004 had an identified interaction with resident #003, resulting in resident #004 falling to the floor.

Interviews with PSW #121, #122, RN #129 confirmed that as a result of the fall, resident #004 sustained the significant injury. Interview with the DOC confirmed that when an incident happened as mentioned above, it should be considered abuse. The DOC acknowledged that the home had failed to protect resident #004 from abuse by resident #003. [s. 19. (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 ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home submitted a CIS report to the MOHLTC, Director, related to staff to resident abuse on an identified date. The CIS report indicated resident #031 was afraid of PSW #122 after an incident happened during a specified care for resident #031. Resident #031 indicated PSW #122 acted in an identified manner during the care, and the resident was upset by the incident. The incident was reported to RPN #126 by resident #031 three days before the CIS report was submitted.

An interview with resident #031 indicated the incident occurred during an identified time period. Resident #031 indicated PSW #122 acted and verbally communicated to him/her in the identified manner when an identified event happened during the specified care. The resident further stated it made him/her feel upset and he/she reported the incident to RPN #126 on an identified date that is three days before the CIS report was submitted. The resident also stated whenever he/she sees the same PSW in the unit or hears the PSW's voice, he/she feels afraid.

The home's policy titled, "Resident Non-Abuse Program" with effective date of August 31, 2016, and reviewed date of July 31, 2016, under procedure, subsection, internal stated, "Anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift."

An interview with RPN #126 indicated that on the identified date mentioned by resident #031, he/she observed the resident upset in an identified home area with an identified person. The RPN stated the resident told him/her that the resident was afraid of PSW #122 and was upset after the above mentioned incident during the specified care. The resident told the RPN that PSW #122 verbally communicated to him/her in the identified manner during the care. The RPN informed the resident that he/she would inform management of the incident. The RPN indicated he/she documented the conversation in a progress note and constituted the incident above to be abuse. The RPN stated he/she did not report the incident to the charge nurse on his/her shift and reported the incident to the DOC three days after the incident had happened, as his/her shift was in an identified time period that management was not in the home. The RPN further indicated it was the

home's expectation that abuse should be reported to the DOC right away and this was not done for the above incident.

An interview with the DOC indicated the home's expectation is for him/her to be informed right away when a family member or resident has a concern relating to allegation of abuse and or neglect. The DOC also stated it is the home's expectation for registered staff and PSWs to report allegations of abuse or neglect to the charge nurse immediately. If an allegation of abuse or neglect is reported when management staff is not present in the home, the charge nurse is to inform the manager on-call of the allegation. The DOC indicated on the day that the CIS report was submitted, he/she was aware of the above incident after reading RPN #126's progress notes dated three days before. The DOC stated the incident was an allegation of abuse and a CIS report was required to be submitted to the MOHLTC, Director, immediately or call the MOHLTC after hours number at the time of the incident. The DOC acknowledged the incident with resident #031 should have been communicated to him/her on the date that the resident reported the incident to RPN #126 as per home's expectation. [s. 20. (1)]

Issued on this 23rd day of May, 2017

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

Original report signed by the inspector.