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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_626501_0007	003220-17, 004813-17, 007834-17, 016492-17, 008949-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

MacKenzie Place
52 George Street NEWMARKET ON L3Y 4V3

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

SUSAN SEMEREDY (501)

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 4, 5, 6, 7, 8, 11, 12, 13 and 14, 2019.

The following intakes related to responsive behaviours and the prevention of abuse were inspected:
#007834-17
#016492-17
#008949-18
#003220-17
#004813-17

Written Notification and Compliance Order related to LTCHA, 2007, s. 6(1), identified in concurrent complaint inspection #2019_626501_0006 related to intake log # 002800-19 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector observed resident to resident interaction and reviewed health care records, the licensee's investigation notes, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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. 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. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The home submitted Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #006 and #007 engaging in an identified activity. Review of the video footage by the home indicated resident #006 and #007 had been engaged in such activity.

A review of resident #006's medical record indicated a progress note described staff member #119 as witnessing resident #006 and #007 engaged in an identified activity. Further review of progress notes indicated the residents were observed engaging in an identified activity on identified dates. A communication resident/family progress note indicated resident #006's SDM was aware. The SDM identified that they had no concerns.

A review of resident #007's progress notes indicated staff member #119 observed resident #007 and #006 engaging in an identified activity. The note indicated resident #007 stated they had engaged in the activity. A progress note indicated resident #007's SDM had no concerns. A note on an identified date indicated to allow the residents to interact. Further incidents of the residents being together were noted up until an identified date.

A review of resident #006's and #007's written plans of care indicated both residents had responsive behaviours but did not describe the activity or provide specific interventions for staff to follow. Resident #006's written plan of care indicated dementia observation system was initiated on an identified date and required increased monitoring and interventions for an identified responsive behaviour. There was no indication what the

identified behaviour was. Resident #007's written plan of care did not indicate there were any specific behaviours but noted to refer to the latest risk management assessments for resident to resident interactions.

An interview with staff member #119 indicated that they were not the primary care giver for either of the above mentioned residents but had reported observing the identified activity. Staff member #119 was informed at some point that resident #006 and #007 could engage in the identified activity. Interviews with primary care givers #107 and #120 and registered staff members #116 and #101 indicated they were to monitor resident #006 and #007 and intervene as required. Both registered staff members confirmed that the plans of care for both residents did not provide any direction for staff to take although progress notes described what staff were to do. Staff member #101 acknowledged that interventions should have been added to the residents' plans of care so all staff would know how to manage the identified activity when it happened.

An interview with DOC #111 indicated the relationship between resident #006 and #007 remained cordial on both sides. DOC #111 stated the management sat with staff and went over how to address these behaviours. DOC #111 confirmed that the written plans of care did not provide clear direction to staff on how to respond to incidents of an identified activity between resident #006 and #007. [s. 6. (1) (c)]

2. The following non-compliance is from inspection #2019_626501_0006:

A family member of resident #001 called the MOHLTC related to resident #001's passing after a fall. According to the family member, staff did not address the resident's responsive behaviours and when a staff member moved the resident in an identified assistive aide they fell. The resident was transferred to the hospital and passed away.

A review of resident #001's medical record indicated the resident was admitted to the home with various identified medical diagnoses. A review of the resident's most recent plan of care indicated the resident was assessed at risk for falls. Review of post fall assessments indicated the resident had several falls since admission. Most of those falls occurred in an identified area of the home and the resident sustained minimal injuries.

According to a progress note made on an identified date, resident #001 fell in an identified area of the home. There was an identified injury and the resident was sent to the hospital. At an identified time, the family notified a registered nurse (RN) that the

resident passed away.

A review of the home's video footage indicated the above mentioned incident was captured by a camera that was located in an identified area of the home. The video showed resident #001 sitting in an assistive aide appearing to have identified responsive behaviours. A staff member was attending to the resident. At one point the staff member was observed to turn the assistive aide which is when the resident was observed to fall. According to DOC #111, another camera in another location of the home did not capture the incident due to the direction and angle of that camera.

During interviews staff member #106 confirmed they were the one attending to resident #001 in the above mentioned video footage. The staff member indicated they were concerned that the resident was having responsive behaviours and did not want to leave them alone.

Further review of the progress notes indicated resident #001 experienced responsive behaviours the previous day and was administered an identified as needed medication. At an identified time, staff member #112 documented the medication was effective. Later on staff member #113 documented an as needed medication was administered because the resident was experiencing identified responsive behaviours. Staff member #108 also documented a behaviour progress note stating that the resident was experiencing identified responsive behaviours and the staff member made an identified intervention to respond these behaviouirs. A progress note later indicated the as needed medication was effective.

During interviews staff members #105, #108, #109 and #106 indicated resident #001 was most likely experiencing responsive behaviours due to an identified trigger. According to these staff members, the resident had identified responsive behaviours and there were identified triggers to such responsive behaviours. Strategies to respond to resident #001's responsive behaviours differed for each staff member.

A review of resident #001's most recent plan of care indicated that there was no focus for responsive behaviours. Under one identified focus, the intervention described an identified trigger but there was no strategy to indicate what staff should do if the resident experienced such a trigger. Under another identified focus, there was no direction to administer medication on an as needed basis for any identified responsive behaviours.

During interviews staff members #101, #108, #109 and #106 confirmed there was no

responsive behaviour focus in resident #001's written plan of care. Staff member #106 indicated that clear directions to respond to resident #001's responsive behaviours would have been especially helpful the day of the above noted fall. During an interview DOC #111 acknowledged there should have been a responsive behaviour focus in the written plan of care which provided the staff with clear directions to respond to resident #001's responsive behaviours. [s. 6. (1) (c)]

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 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.

Three critical incidents system (CIS) reports were submitted to the MOHLTC related to resident #002's responsive behaviours towards resident #003, #004 and #005.

A review of resident #003's medical record indicated a progress note on an identified date documented resident #002 took an identified item and exhibited a responsive behaviour toward resident #003. According to a skin assessment of the same date, resident #003 sustained an identified injury.

A review of resident #004's medical record indicated a progress note on an identified date, documented resident #004 sustained an injury due to another resident.

A review of resident #005's medical record indicated a progress note on an identified date, documented resident #002 exhibited an identified responsive behaviour toward resident #005. Resident #005 sustained an injury. A physician's note on an identified

date indicated resident #005 sustained an injury.

A review of resident #002's medical record indicated the resident was admitted to the home with identified diagnoses. Resident #002's written plan of care indicated the resident exhibits responsive behaviours. According to the plan of care, resident #002 has identified triggers.

A review of external consultations for resident #002 was conducted. In an identified year resident #002 was seen by identified medical professionals and medications to manage specific responsive behaviours were adjusted. In an other identified year, an identified medical professional noted resident #003's responsive behaviours were changing and on an identified date, another medication was added. On a further date, an identified medical professional increased the doses of the medications due to specific responsive behaviours. On an identified date, a behavioural support services team assessed resident #002. The team requested to have an assessment related to specific identified lab results and recommended adjustments in an identified medication regime.

Interviews with staff members #114, #120, #104, #116, #117, #118 and #106 indicated they were aware of resident #002's responsive behaviours, their triggers and strategies that have been developed to respond to these behaviours. All these staff members stated they thought resident #002 was now stable in relation to these responsive behaviours.

An interview with DOC #111 indicated they believed resident #002's behaviours were well managed in order to protect current residents. However, the DOC acknowledged that the home failed to protect resident #003, #004 and #005 from abuse as indicated in the three above noted CIS reports.

The severity of the non-compliance was determined to be a level 2 indicating minimal harm or potential for actual harm. The scope was a level 2 as three out of four residents sampled were involved. The compliance history was a level 2 indicating a previous finding in an unrelated area. According to process, a compliance order would be warranted. However, upon reviewing the compliance history of the issue, it has been confirmed through the inspection that the non-compliance has been addressed and rectified by the home since the non-compliance occurred. [s. 19. (1)]

Issued on this 1st day of April, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2019_626501_0007
Log No. / No de registre :	003220-17, 004813-17, 007834-17, 016492-17, 008949-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 25, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	MacKenzie Place 52 George Street, NEWMARKET, ON, L3Y-4V3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Griffin Allen

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

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCH Act.

Specifically, the licensee must prepare, submit and implement a plan to ensure strategies are developed and implemented to ensure the plans of care set out clear directions to staff and others who provide direct care to all residents, specifically those with responsive behaviours.

The plan must include, but is not limited, to the following:
a. A system to audit the written plans of care for all residents demonstrating responsive behaviours to ensure a responsive behaviour focus has been created that includes specific strategies or interventions to respond to the behaviours.
b. A method to involve front line staff members in the development of such plans.
c. Development of a communication system to ensure all front line staff are aware of the strategies added to the written plan of care.

Please submit the written plan for achieving compliance quoting inspection #2019_626501_0006, to Susan Semeredy, LTC Homes Inspector, MOHLTC, by email to: CentralEastSAO.MOH@ontario.ca by April 8, 2019.

Please ensure that the submitted written plan does not contain any personal information (PI) or Personal Health Information (PHI).

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The home submitted Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #006 and #007 engaging in an identified activity. Review of the video footage by the home indicated resident #006 and #007 had been engaged in such activity.

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with primary care givers #107 and #120 and registered staff members #116 and #101 indicated they were to monitor resident #006 and #007 and intervene as required. Both registered staff members confirmed that the plans of care for both residents did not provide any direction for staff to take although progress notes described what staff were to do. Staff member #101 acknowledged that interventions should have been added to the residents' plans of care so all staff would know how to manage the identified activity when it happened.

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2. The following non-compliance is from inspection #2019_626501_0006:

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The severity of the non-compliance was determined to be a level 3 as there was actual harm to the resident. The scope was a level 2 as it related to two out of three residents sampled indicating a pattern. The compliance history was a level 4 indicating on-going non-compliance with a voluntary plan of correction (VPC). (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee 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 Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Central East Service Area Office