Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
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159, rue Cedar Bureau 403
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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
Sep 4, 2019	2019_680687_0023	003174-19, 006241-19, 010867-19	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

Oak Terrace
291 Mississaga Street West ORILLIA ON L3V 3B9

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

LOVIRIZA CALUZA (687), AMY PAGE (749)

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): August 12 to 16, 2019.

The following intakes were inspected during the Critical Incident System (CIS) Inspection:

- One intake related to a resident fall that resulted in an injury, and

- Two intakes related to staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Regional Manager for Education, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #687 reviewed the home's policy titled "Resident Non-Abuse Program" last revised March 2019, which indicated that, "The home has a zero tolerance for abuse and neglect. Any form of abuse and neglect by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated".

a) The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #003 was allegedly abused by Registered Nurse (RN) #109.

Inspector #687 reviewed the home's policy titled "Resident Non-Abuse Program" last revised March 2019, which indicated that, "The home has a zero tolerance for abuse and neglect. Any form of abuse and neglect by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated".

In a review of the home's internal investigation, resident #003 reported to Personal Support Worker (PSW) #108 that they were abused on a specified date. The internal investigation further indicated that PSW #108 notified RN #110 about this alleged abuse.

In an interview conducted by Inspector #687 with resident #003, they described the non-consensual interaction by RN #109. The resident stated that they waited till the next day and told RN #110 about the incident. The resident further stated that the Administrator, the Director of Care (DOC) and RN #106 arrived to obtain information about this incident and provided emotional support to them.

During an interview with RN #106, they stated that RN #110 notified them of an alleged staff to resident abuse and had requested them to be present to provide emotional support to resident #003. RN #106 further stated that they listened to the conversation between RN #110 and resident #003. RN #106 stated that the resident was very upset and told them of the interactions with RN #109.

In an interview conducted by Inspector #687 with RN #110, they stated that they were notified on a specified date by PSW #108 regarding resident #003's being upset and that something was wrong with the resident. RN #110 went to speak to resident #003 who was emotional at that time. RN #110 further stated that resident #003 informed them of

the actions by RN #109. RN #110 stated that they notified the Administrator and the DOC about this incident and they continued the information gathering from the resident.

In an interview with the DOC, the DOC stated that based on their internal investigation it was substantiated that RN #109 abused resident #003. The police and the College of Nurses (CNO) were notified of RN #109's actions.

b) The home submitted a CI report to the Director, which indicated that resident #002 was allegedly abused by PSW #104.

In a review of the home's internal investigation, resident #002 reported the alleged abuse from PSW #104 to the DOC. The internal investigation described the interaction between PSW #104 towards resident #002.

During an interview conducted by Inspector #687 with resident #002, they described the actions of PSW #104 towards them.

In an interview with PSW #104, they acknowledged their actions towards resident #002 and indicated it was a misunderstanding. The PSW further stated that they did not deliberately intend to hurt the resident's feelings.

During an interview with the DOC, they stated that based on their internal investigation, the alleged abuse incident by PSW #104 to resident #002 was substantiated. [s. 20 (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 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident.

The home submitted a CI report to the Director, which indicated that resident #002 was allegedly abused by Personal Support Worker (PSW) #104 on a specified date.

During a review of the home's internal investigation report in relation to resident #002's alleged abuse by a staff member, Inspector #687 identified a complaint from the resident about the alleged abuse and an additional complaint regarding the resident's continence care needs.

A review of resident #002's electronic care plan record indicated intervention A.

In a review of resident #002's electronic Point of Care (POC) record, it identified an intervention B. In addition, another task for continence care routine was identified as intervention C.

In a review of the home's policy titled "Health Records and Documentation" reviewed date on March 31, 2019, the policy indicated that "A resident's record should be factual, internally consistent, concise and accurate and does not include editorial, comments, speculation or meaningless phrases".

During an interview with resident #002, in relation to their complaint regarding staff members not providing them with their continence care needs, the resident stated that

the staff would provide intervention D.

In an interview with PSW #115 and #120, they stated that resident #002 had a combination of continence care intervention B and D.

In an interview with PSW #116, they stated that resident #002 had no continence care interventions.

In an interview with the Registered Practical Nurse (RPN) #118, they stated that resident #002 had a combination of continence care intervention B and D. The RPN acknowledged that the different interventions for the resident's continence care needs in the electronic care plan and the POC tasks created a confusion and did not provide a clear direction to staff members.

During an interview with the Director of Care (DOC) and the Administrator, they acknowledged that resident #002's electronic care plan and the POC task did not provide clear direction to staff members due to different interventions for the resident's continence care needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #002 as specified in the plan.

The home submitted a CI report to the Director, which indicated that resident #002 was alleged to have been abused by PSW #104 on a specified date.

Inspector #687 reviewed the CI report and identified there was also an allegation from the resident of an improper transfer by the PSW. In the CI report, the resident disclosed that PSW #104 had transferred them in a manner inconsistent with their assessed needs.

A review of resident #002's electronic care plan in effect at that time of the incident indicated in a manner in which resident #002 required assistance with their transfer and positioning needs.

During an interview conducted by Inspector #687 with resident #002, the resident stated that PSW #104 provided assistance and transferred them in a manner inconsistent with their assessed needs.

In an interview conducted with PSW #104, they described the transfer and positioning

requirements of resident #002. The PSW stated that they have access to the resident's care plan and the resident's Kardex. PSW #104 and Inspector #687 reviewed resident #002's care plan in effect at that time and the PSW stated that they were not aware that the resident required specific transfer and positioning requirements different than the assistance they provided to the resident.

During an interview with the DOC and the Administrator, they verified that the staff did not follow the care plan of the resident in relation to their transfer and positioning needs. [s. 6. (7)]

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 written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the report included a description of the individuals involved in the incident including the names of the staff members who responded to the incident.

The home submitted a CI report to the Director, which indicated that resident #003 was allegedly abused by RN #109 on a specified date. The CI report identified the DOC and the Administrator were the only staff members who responded to the incident and failed to identify the names of any staff members or other persons who were present at or discovered the incident.

In a review of the home's internal investigation by Inspector #687, resident #003 reported to PSW #108 that they were abused on a specified date. The internal investigation further indicated that PSW #108 notified RN #110 about this alleged abuse.

In an interview with resident #003, they informed Inspector #687 that they spoke to RN #110 on the specified date about the alleged abuse by RN #109.

In an interview with RN #110, they verified that resident #003 told them about the alleged abuse incident that happened on a specified date involving RN #109. RN #110 further stated PSW #108 notified them of the alleged abuse incident and that RN #106 was present during their conversation with the resident.

In an interview with RN #106, they stated that they were with RN #110 when resident #003 spoke to RN #110 in relation to the alleged abuse involving RN #109.

In a review of a document provided by the home entitled "Critical Incident System Report Required Content" under Appendix C, it indicated that "A description of the individuals involved in the incident, included the name of the staff members who responded or were responding to the incident".

In an interview with the DOC, they verified that PSW #108, RN #106 and RN #110 were initially made aware of the alleged abuse incident of resident #003 by RN #109. The DOC acknowledged that they did not include the names of the staff members in the CIS reporting and that it was an oversight. The DOC further stated that the staff names should have been included in the CIS report but they were not. [s. 104. (1) 2.]

Issued on this 12th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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) :	LOVIRIZA CALUZA (687), AMY PAGE (749)
Inspection No. / No de l’inspection :	2019_680687_0023
Log No. / No de registre :	003174-19, 006241-19, 010867-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 4, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Oak Terrace 291 Mississaga Street West, ORILLIA, ON, L3V-3B9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Annette Schneider

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. 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).

Order / Ordre :

The licensee shall be compliant with s. 20 (1) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must;

a) Ensure that all staff, comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.

b) Develop and implement a process to ensure that staff hired by the home are aware and understand the policy to promote zero tolerance of abuse and neglect of residents; specifically that abuse and neglect are not tolerated, clearly understand what constitutes abuse and neglect and that they must report it immediately.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #687 reviewed the home's policy titled "Resident Non-Abuse Program" last revised March 2019, which indicated that, "The home has a zero tolerance for abuse and neglect. Any form of abuse and neglect by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated".

a) The home submitted a Critical Incident (CI) report to the Director, which

indicated that resident #003 was allegedly abused by Registered Nurse (RN) #109.

Inspector #687 reviewed the home's policy titled "Resident Non-Abuse Program" last revised March 2019, which indicated that, "The home has a zero tolerance for abuse and neglect. Any form of abuse and neglect by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated".

In a review of the home's internal investigation, resident #003 reported to Personal Support Worker (PSW) #108 that they were abused on a specified date. The internal investigation further indicated that PSW #108 notified RN #110 about this alleged abuse.

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In an interview with the DOC, the DOC stated that based on their internal investigation it was substantiated that RN #109 abused resident #003. The police and the College of Nurses (CNO) were notified of RN #109's actions.

(687)

2. b) The home submitted a CI report to the Director, which indicated that resident #002 was allegedly abused by PSW #104.

In a review of the home's internal investigation, resident #002 reported the alleged abuse from PSW #104 to the DOC. The internal investigation described the interaction between PSW #104 towards resident #002.

During an interview conducted by Inspector #687 with resident #002, they described the actions of PSW #104 towards them.

In an interview with PSW #104, they acknowledged their actions towards resident #002 and indicated it was a misunderstanding. The PSW further stated that they did not deliberately intend to hurt the resident's feelings.

During an interview with the DOC, they stated that based on their internal investigation, the alleged abuse incident by PSW #104 to resident #002 was substantiated.

The severity of this issue was determined to be a level three, as there was an actual harm. The scope of the issue was a level two, as it was identified as a pattern to a number of residents. The home had a level three compliance history, as they had one previous non-compliance to the same subsection in the last three years within this section of the LTCHA that included:

- one Written Notification (WN) issued March 21, 2018, during inspection 2018_491647_004.

(687)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 21, 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 4th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Loviriza Caluza

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