Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2021	2021_745690_0025	016305-21	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

TRACY MUCHMAKER (690)

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): December 9-10, 2021, and December 13, 2021.

The following intake was inspected upon during this Critical Incident System inspection:

-One intake, related to an allegation of resident neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Resident Assessment Instrument (RAI) Coordinator, Housekeepers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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. (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 care was provided to a resident, as specified in the plan of care.

An allegation of neglect of a resident was reported to the Director of Care (DOC). The home's investigation notes, identified that a Personal Support Worker (PSW), did not provide assistance as per the resident's plan of care.

A review of documentation for a two month period, identified occasions where the resident did not receive the level of assistance that was identified in their care plan for specified activities of daily living (ADLs)

PSW, and Registered staff, verified that the level of assistance provided to the resident for the specified ADLs was not always provided as per the resident's plan of care. The DOC and Executive Director (ED) verified that care was not provided as per the resident's plan of care.

Sources: The home's investigation notes, a resident's care plan and Point of Care (POC) documentation, interviews with staff, the DOC, and ED. [s. 6. (7)]

2. Another resident's care plan identified that the resident required a specified level of assistance by staff for identified ADLs. Review of POC documentation for a one month period, identified that on multiple occasions, the resident received a different level of assistance for ADLs.

PSW and Registered staff verified that, at times, the resident was not provided with the level of assistance that was identified in the care plan. The DOC and the ED also verified that the resident, was not provided care as per the resident's plan of care.

Sources: A resident's care plan and POC documentation, interviews with staff, the DOC, and ED. [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 care is provided to residents as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse or neglect of a resident by a staff member that resulted in risk of harm to a resident, immediately reported the suspicion to the Director.

Pursuant to s. 152 (2), the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

An allegation of neglect of a resident was reported to the DOC by a PSW, three days after the incident occurred.

Both the DOC and the ED verified that the incident had not been reported immediately, and that they had only become aware of the incident three days after it had occurred.

Sources: A Critical Incident System, the home’s investigation notes, the home's policy titled "Resident Non-Abuse Program-ADMIN1-P10-ENT", dated March 31, 2021, interviews with staff, the DOC, and the ED. [s. 24. (1)]

Issued on this 4th day of January, 2022

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

Original report signed by the inspector.