Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: September 13, 2024
Inspection Number: 2024-1246-0002
Inspection Type: Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Riverbend Place, Cambridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3-6 and 9-10, 2024

The following intake(s) were inspected:

- Intake: #00115541 related to alleged neglect of resident by staff.
- Intake: #00117581 related to alleged neglect of resident by staff.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee failed to report to the Director the results of an investigation undertaken related to an alleged neglect of a resident by staff.

Rationale and Summary
The Director of Care (DOC) submitted a Critical Incident (CI) report to the Director related to the alleged neglect of a resident by two personal support workers (PSW). The CI report was not amended with the results of the home's investigation related to the allegation of staff to resident neglect.

Sources: record reviews of the Critical Incident (CI) report, the home's investigation notes and report; and interview with the Executive Director.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to report a critical incident regarding allegations of neglect of a resident to the Director immediately.

In accordance with FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary
The home suspected neglect of a resident when a personal support worker (PSW) refused to provide them with care. The critical incident occurred on May 4, 2024 and was reported to the Director on May 6, 2024.

By failing to report the incident immediately, the Director was unable to respond to the incident in a timely manner.

Sources: record reviews of the Critical Incident (CI) report; and interviews with Personal Support Worker (PSW), Registered Practical Nurse (RPN), RAI-MDS Coordinator/Staff Educator, and Executive Director (ED).

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director, was implemented.

According to the IPAC Standard for LTCHs dated April 2022, section 7.3 (b) directs the licensee to ensure that audits are performed at least quarterly to ensure that all staff can perform the IPAC skills required for their role.

Rationale and Summary
From June to August, 2024, no audits were completed for the food services department to ensure they could perform the IPAC skills required for their role.

By failing to follow the IPAC Standard and not completing audits at least quarterly, to ensure that all staff could perform the required IPAC skills for their role, there was a risk of transmission of infectious agents.

Sources: interviews with Food Services Manager (FSM) and RAI-MDS Coordinator/Staff Educator; and record reviews of Hand Hygiene and Personal Protective Equipment (PPE) audits completed from June to August 2024, and the IPAC Standard issued on April 2022.

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee failed to ensure that a resident's Substitute Decision-Maker (SDM) was notified within 12 hours upon the licensee becoming aware of an alleged incident of neglect of the resident.

Rationale and Summary
The Director of Care (DOC) was made aware of an allegation of neglect towards a resident by two personal support workers (PSW). The resident's SDM was not notified of the incident.

Sources: record reviews of the Critical Incident (CI) report, the home's investigation notes and report, and a resident's clinical health records; and interviews with the Executive Director (ED), and other staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure that a resident's Substitute Decision Maker (SDM) was notified of the results of an investigation required under subsection 27 (1) of the Act,

immediately upon the completion of the investigation.

According to the FLTCA 2021, s. 27 (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;

Rationale and Summary
The Director of Care (DOC) submitted a CI report related to an allegation of neglect of a resident by two personal support workers (PSW). The resident's SDM was not notified of the results of the investigation.

Sources: record reviews of the Critical Incident (CI) report, the home's investigation notes and report, and a resident's clinical health records; and interviews with the Executive Director (ED), and other staff.