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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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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 29, 2017	2017_659189_0006	027567-16, 007480-17	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive Maple ON L6A 3P8

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 11, 12, 2017

The follow Critical Incident System (CIS) intake were inspected concurrently with this follow up inspection : 007480-17 related to abuse.
A Written Notification and Compliance Order related to O. Reg. 79/10, s. 19 (1), identified in concurrent inspection #2017_378116_0006 (Log #032533-16) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Interim Executive Director, Director of Care (DOC), registered nurse, personal support workers, residents, family members.

During the course of the inspection, the inspector reviewed training materials and relevant policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 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 and free from neglect by the licensee or staff in the home.

On an identified date, the home submitted a Critical Incident System Report (CIS) to the Director reporting an incident of improper/incompetent treatment of a resident that resulted in harm to resident #016. The CIS read as follows:

On an identified date, resident #016 reported to nurse #122 that PSW #110 was getting him/her up this morning, grabbed him/her and caused an injury. According to the resident, he/she said "ouch" and the PSW did not say anything back.

Resident #016 expressed to inspector #116 that sometime last year, during morning care, PSW #110 grabbed the resident and injured him/her. The resident expressed that he/she felt and verbalized pain however, the PSW did not say anything and proceeded with care. Resident #016 further stated that as the care continued PSW #110 made statements towards the resident that made the resident feel afraid.

The inspector interviewed PSW #113 who observed the injury on resident #016's upon commencing the evening shift on the identified date. PSW #113 stated that he/she reported the observations to RN #122.

Inspector #116 interviewed RN #122 regarding the incident. RN #122 reported that he/she could not recall whether he/she immediately reported the suspicions of improper care and/or treatment to the Director however, he/she brought the concerns forward to the DOC via email.

Record review revealed and interviews with the DOC confirmed that an internal investigation was conducted which found that the assertions of improper care and/or treatment to be founded. As a result, PSW #110 was disciplined. The DOC further stated that PSW #110 received retraining on the home's resident abuse policy and customer service training to prevent a further reoccurence.

Review of PSW #110's employee record indicated that during an identified time period , the staff member has been disciplined previously for similar incidents. The employee record indicated PSW #110 received retraining on the home's resident abuse policy and customer service on an identified date, after an unrelated incident of improper care or treatment to a resident.

The licensee failed to protect resident #016 despite a known history of reoccurrence of improper care or treatment displayed by PSW #110. [s. 19.]

2. On an identified date, the home submitted a Critical Incident System Report (CIS) reporting an allegation of staff to resident abuse. The CIS read as follow: On an identified date, resident #008's POA reported inappropriate use of a resident's personal property. POA was concerned about the resident's safety during an identified time.

Interview with the DOC revealed that on an identified date, the Substitute Decision Maker (SDM) for resident #008 came into his/her office expressing concerns regarding the safety of the resident. SDM reported to the DOC that a staff member of the home was using the resident's property inappropriately. The DOC reported to the inspector that an investigation took place and the DOC confirmed the SDM's allegation.

The inspector interviewed resident #008's SDM and confirmed the information that was provided to the DOC. Interview with RN #109 confirmed that he/she did use resident #008's personal property. RN #109 reported that using the resident's personal property was not appropriate. Interview with the DOC confirmed that RN #109 misused resident #008's property, and that the resident was not protected from abuse. [s. 19. (1)]

3. On an identified date, the MOHLTC received a complaint of an allegation of resident to resident abuse.

On July 27, 2016, a compliance order was issued as followed:

Develop, submit and implement a plan to ensure the following:
a) Develop and implement steps to ensure that resident #054 and all residents in the home are protected from abuse and/or neglect by the staff, including training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, and training related to the requirements to provide care to all residents, as identified in their plan of care.
b) Ensure all staff are educated on how to identify environmental hazards and safety for residents.
c) Develop and implement a schedule to test and monitor staff compliance with the home's abuse policies and environmental risks.
d) Maintain a record of who completed the required retraining, when the retraining was completed and what the retraining entailed

This order must be complied with by October 14, 2016.

On April 12, 2017, a follow up inspection was conducted. During interviews with PSW #100, #133, #145, and #101, the staff reported that they did not receive training on how to identify environmental hazards and safety for residents. Interview with the Director of Care (DOC) revealed that a discussion of the inspection report was held with the staff at the nursing/personal support practice meeting in October 2016, however the is no documentation on the required retraining of environmental hazards and risks, or when the retraining was completed, and what the retraining entailed.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The scope of the non-compliance is isolated to Resident #008 and Resident #016.
A review of the Compliance History revealed the following non-compliances related to LTCHA, 2007. s. 19. In July 2016, the home was issued a Compliance Order related to LTCHA, 2007. s. 19, related to failure to protect one resident from abuse within report 2016_440210_0008. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 2nd day of June, 2017

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

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

Ministére 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

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) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2017_659189_0006
Log No. / Registre no:	027567-16, 007480-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 29, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	SHERWOOD COURT LONG TERM CARE CENTRE 300 Ravineview Drive, Maple, ON, L6A-3P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jasdeep Grewal

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2016_440210_0008, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

Develop, submit and implement a plan to ensure the following:

a) Develop and implement steps to ensure that resident #008, resident #016, and all residents in the home are protected from abuse and/or neglect by the staff, including training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents.
b) Ensure all staff are educated on the types of abuse and how to identify abuse.
c) Ensure all staff are educated on how to identify environmental hazards and safety for residents.
d) Maintain a record of who completed the required retraining, when the retraining was completed, and what the retraining entailed.

Plan to be submitted via email to nicole.ranger@ontario.ca by June 12, 2017

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, the home submitted a Critical Incident System Report (CIS) to the Director reporting an incident of improper/incompetent treatment of a resident that resulted in harm to resident #016. The CIS read as follows:

On an identified date, resident #016 reported to nurse #122 that PSW #110 was getting him/her up this morning, grabbed him/her and caused an injury. According to the resident, he/she said "ouch" and the PSW did not say anything back.

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The inspector interviewed PSW #113 who observed the injury on resident #016's upon commencing the evening shift on the identified date. PSW #113 stated that he/she reported the observations to RN #122.

Inspector #116 interviewed RN #122 regarding the incident. RN #122 reported that he/she could not recall whether he/she immediately reported the suspicions of improper care and/or treatment to the Director however, he/she brought the concerns forward to the DOC via email.

Record review revealed and interviews with the DOC confirmed that an internal investigation was conducted which found that the assertions of improper care and/or treatment to be founded. As a result, PSW #110 was disciplined. The DOC further stated that PSW #110 received retraining on the home's resident abuse policy and customer service training to prevent a further reoccurence.

Review of PSW #110's employee record indicated that during an identified time period , the staff member has been disciplined previously for similar incidents. The employee record indicated PSW #110 received retraining on the home's resident abuse policy and customer service on an identified date, after an unrelated incident of improper care or treatment to a resident.

The licensee failed to protect resident #016 despite a known history of reoccurrence of improper care or treatment displayed by PSW #110. [s. 19.] (189)

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in the home are protected from abuse and/or neglect by the staff, including training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, and training related to the requirements to provide care to all residents, as identified in their plan of care.
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d) Maintain a record of who completed the required retraining, when the retraining was completed and what the retraining entailed

This order must be complied with by October 14, 2016.

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confirmed that RN #109 misused resident #008's property, and that the resident was not protected from abuse.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 04, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

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