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

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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
Apr 11, 2019	2019_756583_0009	020191-18, 025007-18, 025804-18, 000576-19	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

Telfer Place
245 Grand River Street North PARIS ON N3L 3V8

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

KELLY HAYES (583)

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 25, 26, 27 and 28, 2019.

The following intakes were completed during this Critical Incident System Inspection:

Follow Up Inspection:
Log #020191-18 for s. 19 related to resident to resident abuse.

Critical Incident System Inspections:
Log #025007-18, CIS 2742-000014-18 related to responsive behaviours.
Log #025804-18, CIS 2742-000017-18 related to injury resulting in transfer to hospital and significant change in a resident.
Log #000576-19, CIS 2742-000001-19 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing staff, Personal Support Workers and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_689586_0018	583

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be notified.

Critical Incident 2742-000017-18, log #025804-18, was submitted in 2018, related to a incident where resident #002 sustained an injury that resulted in the resident being taken to hospital and which resulted in a significant change in the resident's health status.

A review of the home's and the resident's electronic and paper records including the assessment completed by registered nursing staff identified the resident required a transfer to hospital due to pain and an injury to an identified area. Registered staff #100 documented that the Substitute Decision Maker (SDM) would be notified at a later time due to the time the incident occurred and that the resident was being transferred to hospital.

Resident #002's Cognitive Performance Scale and cognitive status was reviewed and it was noted that the resident's SDM was actively involved in the development and implementation of the residents plan of care and decision making.

In documented in the home's progress notes that SDM became aware of the situation at a later time and not by the home.

In an interview with the Administrator and DOC, it was confirmed that the home's expectation was that resident's SDMs were to be notified promptly when there was a serious injury to a resident that requires transfer to hospital. It was confirmed resident #002's SDM should have been notified prior to the resident being transferred. [s. 107. (5)]

Issued on this 11th day of April, 2019

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

Original report signed by the inspector.