Ontario

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

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

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Original Public Report

Report Issue Date: November 7, 2022
Inspection Number: 2022-1236-0001
Inspection Type: Complaint Critical Incident System
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Telfer Place, Paris

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (#740883)	Emma Volpatti Digitally signed by Emma Volpatti Date: 2022.11.14 09:58:58 -05'00'

Additional Inspector(s)
Barbara Grohmann (#720920)

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 19, 21, 24, 25, 26 and 27, 2022

The following intake(s) were inspected:

- Intake # 00002979 relating to the prevention of abuse and neglect
- Intake # 00003453 relating to the prevention of abuse and neglect
- Intake # 00007245 relating to the prevention of abuse and neglect
- Intake # 00004512 for a complaint related to pest control and food quality

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

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Infection Prevention and Control (IPAC)
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: BINDING ON LICENSEES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home was carried out.

The Minister's Directive, titled Covid-19 Guidance Document for Long-Term Care Homes in Ontario, specifies that homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary

The Infection Prevention and Control (IPAC) Manager stated that staff were performing COVID-19 symptom monitoring with temperature checks and it was documented in resident's electronic medical record (EMR). A Registered Nurse (RN) indicated that symptom monitoring, including temperature checks, was not occurring as no resident was sick. The Director of Care (DOC) indicated that the symptom monitoring, along with temperatures, should be documented in assessments once daily.

The home's assessments of symptom monitoring, along with temperatures, were reviewed. During identified days in the review period, the assessments were missing for some or all residents.

By not consistently ensuring that all residents are assessed at least daily for signs and symptoms of COVID-19, including temperature checks, there was a risk of not identifying signs and/or symptoms that may require additional action.

Sources: Interviews with the IPAC Manager and DOC, review of resident's clinical records, Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (October 14, 2022). **[740883]**

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.

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

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director on an identified date, reporting an incident of abuse by one resident to another resident.

A review of a resident's clinical record indicated a Personal Support Worker (PSW) had reported to a Registered Practical Nurse (RPN) that they had observed a resident inappropriately touching another resident. The RPN confirmed that they immediately reported the incident to a member of the management team.

The DOC acknowledged that they were made aware of the incident on the date it occurred but did not report it to the Director until two days later.

Sources: Interviews with the DOC and RPN, resident's progress notes, CIS report. **[740883]**

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 s. 20 (1)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 20 (1) of LTCHA.

The licensee has failed to ensure that their policy to promote zero tolerance of abuse and neglect of

residents was complied with.

Rationale and Summary

A CIS Report was submitted to the Director on an identified date, reporting an incident of abuse by one resident to another resident.

According to the home's policy titled Resident Non-Abuse Program, any person who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director (ED), or if unavailable, to the most senior supervisor on shift.

Upon review of a residents clinical record, an RN documented that on an identified date, a resident had been observed inappropriately touching another resident. The resident then became upset and yelled at the other resident. It was not indicated whether this incident was reported to anyone.

The DOC acknowledged that they, nor the ED, were made aware of the incident until twelve days later. Upon becoming aware, the DOC informed the Director and began an investigation into the incident.

Sources: Interviews with the DOC, the home's policy titled Resident Non-Abuse Program - reviewed March 31, 2022, resident's clinical record, CIS report. **[740883]**

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

A. Non-compliance with: LTCHA, 2007 s. 19 (1)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 19 (1) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 24 (1) of FLTCA.

The licensee has failed to ensure that a resident was protected from abuse by another resident.

Rationale and Summary

The home submitted two CIS reports relating to abuse of a resident.

On an identified date in 2021, an RPN documented in a resident's clinical record that a resident was coming inside of the building from the courtyard area. Another resident attempted to touch the resident inappropriately. The resident stated no and pushed the other resident's hands away. The RPN confirmed that the resident exhibited no distress after the incident. On another identified date, an RN documented in a resident's clinical record that a resident grabbed another resident inappropriately. The CIS reported the other resident became angry at the resident and attempted to hit them. The RN confirmed that other resident was initially upset and angry after the incident.

The DOC acknowledged that the two incidents were not consensual.

Failing to protect a resident from abuse by another resident had the potential to cause significant harm. During the time of the inspection, interventions were in place to minimize the risk of this occurring again.

Sources: Interviews with the DOC and other staff, the Long Term Care Home's (LTCH's) investigation notes, resident's clinical record, CIS report. **[740883]**

B. Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse by another resident.

Rationale and Summary

The home submitted a Critical Incident Report for a resident relating to sexual abuse:

1. On an identified date in 2022, a resident was observed to have inappropriately touched another resident.

An RN confirmed that on that identified date, a PSW approached them and stated they had witnessed a resident inappropriately touch another resident.

An analysis of the statement the PSW had given during the investigation into the incident by the licensee

showed that they were walking down the hallway when they noticed a resident inappropriately touching another resident.

The DOC acknowledged that the incident was not consensual.

Failing to protect a resident from abuse by another resident had the potential to cause significant harm. During the time of the inspection, interventions were in place to minimize the risk of this occurring again.

Sources: Interviews with the DOC and other staff, the LTCH's investigation notes, resident's clinical record, CIS report. **[740883]**