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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2013	2013_181105_0015	L-000182-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

TRILLIUM COURT
550 PHILIP PLACE, KINCARDINE, ON, N2Z-3A6

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

JUNE OSBORN (105)

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): April 19, 2013

L-000182-13

During the course of the inspection, the inspector(s) spoke with the Executive Director and the Corporate Nurse Clinician.

During the course of the inspection, the inspector(s) reviewed the critical incident.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (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). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of the investigation of the alleged abuse is noted in Critical Incident reported to the Director.
An interview with the Executive Director revealed there was no update to the Critical Incident concerning the results of the investigation since it was submitted.
This was confirmed by the Executive Director. [s. 23. (2)]

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 the licensee reports to the Director the results of every investigation under clause(1)(a), and every action taken under clause (1)(b)., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (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,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(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. O. Reg. 79/10, s. 97 (1).

s. 97. (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 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident, were notified within 12 hours upon becoming aware an alleged abuse.
An interview with the Executive Director revealed that only the Substitute Decision Maker of 1 of 4 residents was notified of an alleged abuse.
This is reflected in the Critical Incident Report submitted. [s. 97. (1) (b)]

2. The licensee has failed to ensure that the resident's substitute decision maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon completion of the investigation.
An interview with the Executive Director revealed that the Substitute Decision Makers for 4 of 4 residents were not notified of the results of the investigation.
This is reflected in the Critical Incident Report submitted. [s. 97. (2)]

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 the licensee will notify the resident's Substitute Decision Maker or any other person specified by the resident, within 12 hours of becoming aware of any alleged, suspected or witnessed abuse of said resident and will immediately notify these same parties of the results of the investigation upon its completion., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to make a report to the Director, that included the following material in writing with respect to the alleged abuse of several residents that led to the report.
The Critical Incident Report did not include a description of the individuals involved in the incident, including, the names of all the residents, the names of all the staff who were present or discovered the incident, and names of staff members who responded or are responding to the incident.
This was confirmed by the Executive Director. [s. 104. (1) 2.]

2. The Critical Incident did not include the actions taken in response to the incident, including, a) what care was given or action taken as a result of the incident, and by whom, b) the names of the family members, person of importance or Substitute Decision Makers notified, and c) the outcome or current status of the individual or individuals who were involved in the incident.
This was confirmed by the Executive Director. [s. 104. (1) 3.]

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 reports to the Director under subsection 23(2) of the Act shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone. 1.names of all residents, and staff who are present or responding to the incident and 2. what care was given or action taken as a result of the incident, and by whom, 3. the names of the family members, person of importance or Substitute Decision Makers notified, and 4. the outcome or current status of the individual or individuals who were involved in the incident., to be implemented voluntarily.

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Issued on this 24th day of April, 2013

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