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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2015	2015_378116_0010	T-1035-14/T-1444-12/T-1035-14/T-2327-15/T-2225-15/T-646-14/T-753-14	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

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON M4E 2V6

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

SARAN DANIEL-DODD (116), JUDITH HART (513)

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): June 2, 3, 5, 8, 9, 10, 11, 2015.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), associate director of care (ADOC), staff educator (SE), registered nursing staff, personal support workers (PSWs), dietary aide, residents, substitute decision makers (SDMs) and family members of residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 VPC(s)**
- **0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident’s direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
  i. participate fully in the development, implementation, review and revision of his or her plan of care,
  ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
  iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
  iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and

friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in

order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident is to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity.

Record review of the written plan of care for resident #004 indicated the resident is resistive and aggressive during care.

On an identified date, staff member (A) reported to the DOC and the ADOC an incident that occurred on an identified date, whereupon he/she witnessed staff member (B) physically restrain resident #004 while attempting to administer scheduled medications.

Interviews held with staff member (A) and staff member (B) provided conflicting information regarding the event that occurred. Staff member (B) confirmed that he/she raised his/her tone of voice while attempting to manage a resident to resident altercation between resident #004 and resident #006. Staff member (B) confirmed that his/her tone of voice was disturbing to staff and residents and confirmed altering his/her tone once it was brought to his/her attention by staff member (A). Staff member (B) further confirmed re-approaching resident #004 who then took the scheduled medications.

An interview held with the DOC confirmed that the identified staff member did not treat the resident with respect and courtesy and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. [s. 3. (1)]

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 that every resident is to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had 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 has occurred, immediately report the suspicion and the information upon which it was based to the Director.

Record review of the written plan of care for resident #004 indicated the resident is resistive and aggressive during care.

On an identified date, registered staff member (A) reported to the DOC and the ADOC an incident that occurred on an identified date, whereupon he/she witnessed staff member (B) physically restrain resident #004 while attempting to administer scheduled medications. A critical incident report was submitted to the Director four days after the incident occurred.

Interviews held with staff member (A) and the DOC confirmed that the incident of suspected staff to resident abuse was not reported immediately as per the requirement. [s. 24. (1)]

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 that the person who had 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 has occurred, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The written plan of care for resident #003 indicates that the resident requires the assistance of two staff to perform safe transfers and repositioning at all times.

On an identified date, the licensee submitted a critical incident to the Director notifying that on an identified date, during repositioning, the resident hit a disclosed area of his/her body while two PSWs attempted to reposition the resident in bed. The resident sustained an identified injury as a result of the incident.

Record review revealed and interviews with an identified PSW and the DOC confirmed that the resident was not repositioned in a safe manner which resulted in an injury. The home initiated disciplinary measures and provided retraining on safe transfers and repositioning to the identified staff [s. 36.].

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 that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the duty to make mandatory reports under section 24.

A review of the homes non- abuse retraining records was conducted for the mandatory training in 2014 revealed that the education material does not include/outline the requirements to make mandatory reports under section 24.

Interviews with multiple members of the home’s front line staff which consisted of registered staff, PSWs and members of management revealed that employees are not trained in the area of mandatory reporting under section 24 of the Long Term Care Homes Act (LTCHA), of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.
Staff interviews confirmed that staff are made aware of the need to report abuse of a resident to their supervisor or a member of management however, numerous staff members, including management staff, are not aware of the requirement for anyone who suspects abuse of a resident to immediately report the suspected abuse to the Director under the LTCHA, and that it is an offense to not do so. [s. 76. (4)]

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 that all staff have received retraining annually relating to the duty to make mandatory reports under section 24, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

On an identified date, the licensee reported a CIS whereby, an identified PSW reported that resident #005's arm was observed to be banged against an identified resident's wheelchair. The initial assessment revealed no injury and the resident did not express any pain. The day following the incident, the resident and the resident's substitute decision-maker (SDM) reported to the Administrator that an identified staff member grabbed him/her by the hand to pull the wheelchair and bruised him/her. An assessment was conducted on the day after the incident, which revealed bruising to an identified area of the resident's hand. As per the submitted CIS, the home conducted an internal investigation where the assertions of rough handling were not supported. The resident's SDM was not satisfied with the results of the investigation and felt the resident was abused.

A review of the resident's health record and complaints binder for 2014-2105 were reviewed. There was no documentation to support that an initial or follow up investigation was conducted to verify the allegations. Upon inquiry with the DOC/ADOC it was revealed that the home encountered technical difficulties after the incident occurred and were unable to produce a documented record of the investigation and the nature of the verbal complaint. There was no record available to support the type of action taken, the final resolution and any response made by the complainant. [s. 101. (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 that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

The home's policy entitled "Head to Toe Skin Assessment"(LTC-E-90-05-March 2014) indicates that a head to toe skin assessment is to be completed by a nurse for all residents under the following criteria: whenever there is a change in health status that affects skin integrity.

The home did not comply with completing a head to toe skin assessment for resident #004. On an identified date, registered staff member (A) reported to the DOC and the ADOC an incident that occurred on an identified date, whereupon he/she witnessed staff member (B) physically restrain resident #004 while attempting to administer scheduled medications. A head to toe assessment was not completed until four days after the incident. The head to toe assessment revealed several bruises on identified areas of resident #004's body.

Interviews held with registered staff members and the DOC confirmed that a head to toe assessment should have been completed immediately after the incident. [s. 8. (1) (b)]

2. On an identified date, the licensee submitted a CIS to the Director reporting that during transporting from an identified area in the home, the wheelchair of resident #005 and another resident's wheelchair came into contact with each other. Upon contact the PSW indicated checking resident #005's arm and reported the incident to the registered staff. The progress notes indicated that there was no apparent injury and the resident did not complain of pain. Two days after the incident, an identified PSW reported observing a bruise to resident #005's arm.

A head to toe skin assessment was not completed upon incident or thereafter as per the homes policy. [s. 8. (1) (b)]

Issued on this 13th day of July, 2015

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

Original report signed by the inspector.