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
Direction de l'amélioration de la performance et de la conformité

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
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_252513_0013	T-2237-15	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

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, 17, 18, and 19, 2015.

The following inspections were conducted concurrently: T-1206-14, T-1367-14, T-1471-14, and T-2335-15.

During the course of the inspection, the inspector(s) spoke with the resident, resident's daughters and power of attorney, personal support workers (PSWs), registered staff, and Director of Care (DOC).

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.

- **2 WN(s)**
- **0 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. 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 failed to ensure to report to the Director the results of every investigation undertaken for every alleged, suspected, witnessed incident that the licensee knows of, or that is reported to the licensee.

The critical incident system report for a specified date, and on interview with the resident's identified family member on a specified date, revealed that resident #001 called his/her family member and alleged that a staff member moved him/her in bed that caused an identified injury during repositioning. When the resident made an identified statement, he/she alleged the staff member responded with an identified statement.

Review of the progress notes for a specified date, revealed that the home notified the police about the resident's allegation. The home's investigation report revealed that staff member #102 was immediately suspended during the home's investigation. The home or police did not have any findings of abuse.

Interview with the Director of Care confirmed the licensee did not communicate to the Director the findings of the home's investigation. [s. 23. (2)]

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. (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 failed to ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation under subsection 23(1) of the Act, immediately upon completion of the investigation.

Review of critical incident system report #2589-000014-15 for a specified date, and on interview with the resident's identified family member on a specified date, revealed that resident #001 called his/her identified family member and alleged that on the night shift of a specified date, a staff member moved him/her in bed so that it caused an identified injury during repositioning. When the resident made an identified statement, he/she alleged the staff member responded with an identified statement.

Review of the progress notes for a specified date, revealed that the home notified the police about the resident's allegation. The home's investigation report revealed that staff member #102 was immediately suspended during the home's investigation. The home or police did not have any findings of abuse.

Interview with the resident's identified family member, who reported the allegation to the home, and the resident's Power of Attorney (POA), indicated that the home did not contact either person following the completion of the home's investigation.

Interview with the Director of Care confirmed that the resident's identified family member or POA were not contacted by the home following completion of the home's investigation. [s. 97. (2)]

Issued on this 31st day of July, 2015

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

Original report signed by the inspector.