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
Feb 5, 2019	2019_654618_0002	019706-17	Complaint

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

Main Street Terrace
77 Main Street TORONTO ON M4E 2V6

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

CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 22, 23, 24, 25, 28, 29, 30, 2019.

The following Complaint intake Log #019706-17, related to reporting and complaints of alleged abuse, personal support services, and medication administration were inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN), and Personal Support Worker (PSW) and resident's substitute decision maker.

During the course of the inspection, observed staff to resident interaction, reviewed resident health records.

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

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)**

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 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 :

The Licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse had occurred immediately reported the suspicion and the information upon which it was based to the Director.

This inspection was initiated as a result of complaint intake log which included an allegation of abuse of resident #001.

Interview with the complainant revealed that on an identified date in 2017, resident #001 reported that they had been pushed by a co-resident, and sustained injuries consistent with a physical altercation.

Record review for the identified incident indicated that the resident was found on the floor at their bedside, and when asked by RPN #106 , the resident indicated that they had been pushed by co-resident #002.

Post fall assessments were conducted and no injury was identified at the time.

Record review of resident #002's progress notes for the time of the incident, indicated that this resident was sitting in their wheelchair, facing resident #001's bed, and when asked, they denied they had pushed resident #001.

Interview with PSW #105 identified resident #002's night time habits and responsive behaviours.

Interview with RPN #106, revealed that they could not determine if resident #001 had been pushed, but that the allegation made by resident #001 that they had been pushed should have been reported as alleged or suspected abuse.

Interview with ADOC confirmed that the allegation of being pushed by co-resident, made by resident #001, should have been reported as alleged or suspected abuse.

Issued on this 5th day of February, 2019

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

Original report signed by the inspector.