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 le Loi de 2007 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 25, 2018;	2018_418615_0002 (A2)	029702-17, 000614-18	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

Iler Lodge
111 Iler Avenue ESSEX ON N8M 1T6

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

Amended by NEIL KIKUTA (658) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

This order has been closed due to the fact that this licensee is no longer responsible for the management of this long-term care home as of April 27, 2018. The new licensee will be responsible to ensure compliance with the Long-Term Care Homes Act, 2007 as per the conditions of their licence.

Issued on this 25 day of April 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by NEIL KIKUTA (658) - (A2)

Inspection No. / No de l'inspection : 2018_418615_0002 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 029702-17, 000614-18 (A2)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Apr 25, 2018;(A2)

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Iler Lodge
111 Iler Avenue, ESSEX, ON, N8M-1T6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Elizabeth Desjarlais-Tefft

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

(A2)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

(A2)
The following Order has been rescinded:

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25 day of April 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by NEIL KIKUTA - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : London

Ontario

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Licensee/Titulaire de permis

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5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Iler Lodge
111 Iler Avenue ESSEX ON N8M 1T6

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

Amended by NEIL KIKUTA (658) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 10, 11 and 12, 2018.

The following inspections were conducted:

Complaint IL-54906-LO/Log #000614-18 related to continence care and bowel management, plan of care, director of nursing and personal care and duty to protect;

Complaint IL-54932-LO/Log #029702-17 related to alleged neglect of a resident;

Complaint IL-54447-LO/Log # 028033-17 related to plan of care;

Critical Incident System report # 2129-000063-17/Log #001179-18 related to alleged abuse of a resident by staff;

Critical Incident System report # 2129-000059-17/Log #027925-17 related to alleged abuse of a resident by staff;

Critical Incident System report #2129-000031-17/Log #014664-17 related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), a Regional Manager of Clinical Services (RMCS), a Manager of Clinical Support (MCS), a Registered Dietician (RD), an Environment Service

Aide, a Registered Nurse (RN), three Registered Practical Nurses (RPNs), six Health Care Aides (HCAs), two residents and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.

- **6 WN(s)**
- **2 VPC(s)**
- **2 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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A review of a complaint report documented that the complainant reported concerns regarding lack of care by staff to the resident. They stated that the resident called the complainant, upset and told them that they asked staff for help with a specific care task and it was not provided.

A review of the current care plan in Point Click Care (PCC) documented that the resident was incontinent.

A review of the most recent completed Minimum Data Set (MDS) assessment, on a specific date, documented that the resident was frequently incontinent. The Incontinence Resident Assessment Profile (RAP) documented that the resident had incontinence and continued to require extensive assistance. The resident did not have a “Continence Assessment 2016” completed when the most recent change in status documented a change in incontinence function as part of an MDS assessment. All MDS assessments completed since admission documented that the resident tended to be incontinent at least daily.

The "Assessment" tab in PCC did not have any documented continence assessment completed for the resident. The most recent version of the continence assessment was titled, "Continence Assessment 2016" and was not completed.

On a specific date, a RPN, reviewed the PCC completion of an continence assessment and acknowledged that there had not been an assessment completed in PCC since the resident's admission. The RPN shared that a continence assessment was to be completed on admission, and when there had been a change in continence status.

On a specific date, a HCA shared that the resident wore an incontinence product for daily incontinence and was also cared for routinely.

A review of the “Continence Care-Change of Continence” policy index number “CARE2-O10-01” last reviewed July 31, 2016, stated the nurse would complete the

“Continence Assessment (PCC)” with a change in continence status.

On a specific date, the RMCS and the ED stated the greatest contributing factor related to the incompletion of the continence assessments for multiple residents was that nursing staff did not know they had to complete them in the absence of the previous ADOC and DOC. The RMCS shared that the previous ADOC and DOC did all assessments for all residents and when they were no longer employed in the home, the assessments were missed. Both the RMCS and the ED acknowledged that each resident was to be assessed for continence on admission and when there was a change in status of bladder and/or bowel function. [s. 51. (2) (a)]

2. A second resident's Admission MDS assessment documented that the resident had complete control of continence function. Review of the "Continence Assessment 2016" completed in PCC on a different date documented that the resident was continent. Since the admission MDS assessment, the resident's continence function had declined with no other "Continence Assessment 2016" completed.

On a specific date, a RPN reviewed the PCC completion of a continence assessment and acknowledged that there had not been an assessment completed for the resident since their admission.

On a specific date, a HCA shared that the resident was incontinent at times.

On a specific date, the RMCS and the ED verified that a "Continence Assessment 2016" should have been completed for the resident when there was a change in the resident's continence. [s. 51. (2) (a)]

3. A third resident was admitted to the home and experienced an infection shortly after. The resident's MDS Admission assessment at a later date stated that the resident was frequently incontinent and that incontinence products were used.

A review of the resident's clinical electronic and paper records showed no documented evidence that the resident received a continence assessment since their admission to the home or when there was a change in their condition.

A review of the home's policy #CARE2-O10-02, reviewed July 31, 2016, stated "Procedure. The nurse will: complete the Move-in Assessment/Plan of Care to

identify the level of continence. Initiate 3-Day Continence Diary for the UCP to complete. Complete Continence Assessment (PCC)".

During interviews, a RN, a RPN and a HCA stated that the resident was incontinent and had not received a continence assessment since their admission to the home or when the use of a catheter was needed.

During an interview, the RCMS stated that the Continence Assessment 2016 was piloted in 2016 and went live the summer of 2017 and that a previous continence assessment was used and had since retired. The RCMS and ED #100, both said that it would be the home's expectation that continence assessments be completed on admission and when there was a change in the resident's needs.

The licensee has failed to ensure that the three residents who were incontinent, received an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. [s. 51. (2) (a)]

Additional Required Actions:

(A2)The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for at least 35 hours per week in a home with a licensed bed capacity of 65 beds or more.

During the entrance conference in the home, the Inspector spoke with the ED and the RMCS. The ED stated that the home had no DOC since October 13, 2017 and that they were filling that position on addition of the ED position. The ED and the RMCS both said that the home had 104 beds.

During a different interview, the ED and the RMCS, were asked how the home met the legislative requirement regarding having a DOC on site 35 hours per week and an Administrator on site 35 hours per week. They responded that a RMCS had been filling in, but not sure how many hours per week. The ED stated that a new DOC was to commence in that position on January 19, 2018 and ending on July 20, 2018. The ED stated that they fired the previous DOC and ADOC on May 11, 2017, and then the home had no DOC until July 24, 2017. A DOC was hired from July 24, 2017 to October 13, 2017.

A review of the home's documentation "DOC support/coverage" calendar from October 13, 2017 to January 19, 2018" indicated that only the weeks of November 20 to 24, 2017, and January 8 to 12, 2018, the DOC position was covered for 35 hours per week. There was no documented evidence that there was DOC coverage from May 13, 2017 to July 24, 2017.

During an interview a RPN stated that a sub-DOC was covering and believed it was the ED.

During an interview, a RPN said that the ED fired the DOC and ADOC almost a

year ago and since then, there has been no leadership or consistency on what staff had to do. The RPN stated that they felt that it could be risky for the care of the residents in the home.

During an interview, a RN said that there had been no DOC since June or July, and one DOC for a very short time. A RN stated that managers would come in, and fill in here and there, but it has been very brief.

The ED and the RMCS stated that the expectation was that a DOC would be working in the home on a regular basis for 35 hours per week to meet the legislation.

The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home at least 35 hours per week. [s. 213. (1) 5.]

Additional Required Actions:

(A2)The following order(s) have been rescinded:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of a complaint documented that the complainant reported concerns regarding the care of a resident's specific condition.

The resident was admitted to the home with a specific diagnosis and treatment schedule.

A review of the physician's order for the resident indicated the registered staff to complete observation after the resident's treatment. The resident's care plan indicated different care for the registered staff after the resident's treatment.

During interviews, a RN and a RPN, both stated that the resident was receiving a treatment a number of days per week and the RN would complete observation as per the physician's order. The RN and the RPN stated that the resident's care plan did not reflect the resident's change in needs and that the care set out in the plan was no longer necessary.

During an interview, the ED, stated that the resident's care plan did not reflect the resident's needs and that they would expect that the care plan be updated to the resident's current needs.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A CIS report was submitted on a specific date to the MOHLTC related to alleged verbal abuse to a resident from a HCA.

Section 2 (1) of the Ontario Regulation 79/10 defines “verbal abuse” as, "(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

A review of the home's policy #ADMIN1-P10-ENT, reviewed July 31, 2016, stated "Revera is committed to providing a safe and supportive environment in which all

Residents/clients are treated with dignity and respect. All employees must protect the rights of each and every Resident entrusted to their care".

A review of the CIS report stated that on a specific date, it was reported to the ED, by a staff member that they overheard a HCA call the resident an inappropriate name. The resident, who was cognitively impaired, needed care provided for them.

A review of the home's investigation included a letter to the HCA received by the ED, on a specific date, indicated that the HCA was reprimanded for verbal abuse of the resident.

During an interview a HCA stated that this HCA verbally abused another resident previously and was reported to the management when they came back from the holidays and the HCA was suspended during the investigation.

During an interview, the ED stated that in both incidents verbal abuse had occurred from HCA to two residents, and that the home's expectation was zero tolerance for abuse. [s. 19. (1)]

2. A second CIS report was submitted on a specific date to the MOHLTC related to alleged verbal abuse to a resident from the same HCA.

A Complaint was also submitted on a specific date to the MOHLTC related to alleged neglect of a resident.

A review of the home's investigation included a letter to the HCA received by the ED, on a specific date, indicated that the HCA was reprimanded for verbal abuse and refusing to provide care to the resident.

During a telephone interview, the complainant stated that on a specific date, they overheard a HCA yelling at the resident and that two other HCAs overheard the incident. The complainant stated that they approached the ED at that time to report the incident.

During an interview, a HCA stated that on the specific date they witnessed the HCA raised their voice at the resident and said inappropriate comments in front of the resident.

During an interview, the resident, said that they remembered the incident when the

HCA was yelling at them and said they felt belittled and upset. The resident said that HCA yelled at them several times in the past, that this was not the only incident.

During an interview, the ED stated that it was verbal abuse and that the home's expectation was zero tolerance for abuse.

The licensee has failed to ensure that the two residents were protected from verbal abuse by anyone. [s. 19. (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 residents were protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted on a specific date to the MOHLTC related to alleged verbal abuse to a resident from a HCA.

A review of the CIS report stated that on a specific date, it was reported to the ED, by a HCA that they witnessed a HCA verbally abusing a resident two days before.

A review of the home's policy #ADMIN-O10.01 "Mandatory Reporting of Resident Abuse or Neglect" stated "Where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately verbally report the suspicion and the information upon which it is based to the person in charge (i.e. the nurse on duty "the Nurse"). They will then together immediately report this to their legislative Authority as per legislation (Ont-Director of the MOHLTC in accordance with Critical Incident Reporting Requirements). Failure to report abuse or neglect of a Resident suggests that the staff member has condoned the misconduct, which can result in that staff member receiving the same disciplinary action as is given to the abuser".

During an interview, the ED stated that all staff were trained on abuse and that they knew they had to report abuse immediately. The ED stated that a HCA waited two days to report the abuse and that it would be expected that the person witnessing abuse would report it immediately to the person in charge.

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that symptoms of infection in residents were monitored on every shift in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices.

A resident's MDS Admission assessment indicated, they were experiencing incontinence and had no signs of infection.

A review of the resident progress notes indicated that the resident was experiencing symptoms of an infection on a specific date and antibiotics were prescribed by the physician.

A review of the home's policy #IPC6-P10, reviewed December 21, 2016, stated "Infection surveillance and disease reporting shall be carried out in a consistent manner to monitor and minimize the number of nosocomial infections and outbreaks in the home. There will be a systematic method of tracking, consolidating and analyzing infection surveillance information to identify clusters, trends, and outbreaks".

A review of the resident's progress notes revealed that signs of infections with the resident were not monitored and documented on 10 days and different shifts and the Daily Infection Control for Infection Form for the month of that period did not include the resident.

During an interview, a RN and a RPN stated that the resident contracted an infection on a specific date and the resident's signs and symptoms of infections were not monitored on each shift or on the Daily Infection Control for Infection Form and that it would be expected that any resident with signs of infection be monitored on every shift.

During an interview, the ED stated that the resident contracted an infection on a specific date and that the home’s expectation would be that staff would monitor symptoms of infection in residents on every shift.

The licensee has failed to ensure that symptoms of infection in the resident were monitored on every shift in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices. [s. 229. (5) (a)]

Issued on this 25 day of April 2018 (A2)

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

Original report signed by the inspector.