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
Jan 9, 2019	2018_781729_0003	029179-16, 025667-17, 025977-17, 026947-17, 028514-17, 029392-17, 000188-18, 001185-18, 006517-18, 007152-18, 017312-18, 020231-18, 025667-18	Critical Incident System

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

Summit Place
850 - 4th Street East OWEN SOUND ON N4K 6A3

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

KIM BYBERG (729), SHARON PERRY (155)

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): December 11, 12, 14, 17, 18, 19, 20, 21, 2018.

The following Intakes were completed in this Critical Incident System Inspection:
-Log #026947-17
-Log #029392-17
-Log #028514-17 were all related to the same issue of alleged abuse;

-Log# 025667-18
-Log #017312-18
-Log #025667-17
-Log #029179-17
-Log #025977-17
-Log #006517-18
-Log #007152-18
-Log #020231-18
-Log #000188-18 were all related to an injury that resulted in the transfer to hospital with significant change in status; and Log #00115-18 was related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Care, Resident Care Coordinator, Registered Nurse, Registered Practical Nurse, Personal Support Worker, and Residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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	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. 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 protect residents from abuse by anyone.

O. Reg. 79/10 states that "physical abuse" means:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

The following is further evidence to support the order issued on January 7, 2018, during the Resident Quality Inspection 2017_580568_0026 with a compliance due date of February 28, 2018.

Two critical incident (CI) reports were submitted to the Ministry of Health and Long Term Care (MOHLTC), stating resident #011 was physically abusive towards resident #012 and resident #13.

A review of resident #011's plan of care did not reveal any new or additional responsive behaviour interventions as a result of the first altercation. The home discontinued the fifteen minute monitoring of resident #011 within twenty-four hours of the incident. After the second physical abuse incident, the Physician made medication changes to resident #011's medication regime and the home commenced documenting every fifteen minute monitoring of the resident.

The home had an internal responsive behaviour team, however, after a review of the residents plan of care, there was no documentation to support that they assessed resident #011 or re-evaluated their plan of care as a result of the physical altercations. Resident #011 continued to have multiple physical altercations with co-residents over the

next two months.

RPN #125 shared that they usually implement DOS charting and every fifteen minute checks on residents that exhibit new or worsening responsive behaviours. They shared that stopping the every fifteen minute checks twenty-four hours after an altercation would be too soon. RPN #125 reviewed the documentation and was not able to tell what interventions the staff did to prevent further physical altercations between resident #011 and co-residents and did not feel that resident #012 and #013 were protected from abuse.

The executive director shared that the home's dementia care policy states to have one-to-one staff to monitor residents, but every fifteen minute checks were put into place.

Multiple incidents of physical abuse occurred by resident #011 towards co-residents, the home did not clearly document responsive behaviour interventions or strategies to prevent recurrence. The licensee failed to protect residents #012 and #013 from abuse. [s. 19. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).
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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The Licensee has failed to include in their report to the Director within 10 days of becoming aware of the incident, the actions taken by the home, the outcome or current status of the individual, the analysis and follow-up action plan including immediate and long term action to prevent the situation or recurrence.

A critical incident (CI) report submitted to the MOHLTC stated resident #002 was walking when they lost their balance and fell. The fall caused an injury that resulted in a significant change in their health status and required a transfer to hospital.

The Director of Care (DOC) initiated the CI report stating that resident #002 was at the hospital, and was awaiting surgery. One month later, an inspector from the MOHLTC contacted the home and requested that they provide an update to the CI report to include what long term actions the home planned to do to correct, and prevent recurrence.

The Executive Director (ED) shared that the CI report was not updated within the timelines and that they were aware of the reporting requirements to the Director.

The initial report did not include the immediate or long term actions that the home would take to prevent recurrence, what the families response to the incident was, nor what fall prevention interventions that the home had in place prior to resident #002 falling.

The Licensee has failed to include in their report to the Director within 10 days of becoming aware of the incident, the actions taken by the home, the outcome or current status of the individual, the analysis and follow-up action plan including immediate and long term action to prevent the situation or recurrence. [s. 107. (4)]

Issued on this 9th day of January, 2019

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

Original report signed by the inspector.