Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Oct 8, 2020	2020_835767_0012	003010-20, 003646-20, 005948-20, 009974-20, 017681-20, 018932-20	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

SARAH INGLIS (767), SHERRI COOK (633)

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): September 15-18, 2020.

The following intakes were completed in this Critical Incident Inspection: log #003646-20, log #003010-20, and log #009974-20, related to falls. Log #018932-20, and log #017681-20, related to staff to resident abuse and log #005948-20, related to missing medication.

During the course of the inspection, inspectors observed resident's, resident and staff interactions,clinical records and plan of care for the identified residents were reviewed.

During the course of the inspection, the inspector(s) spoke with the Regional Director, the Regional Manager of Clinical Services, the Executive Director (E.D), the Director of Care (DOC), the Assistant Director of Care (ADOC), the RAI Coordinator, the Resident Care Coordinator, the Recreation Manager, the Nutritional Manager, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's) and resident's.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 failed to ensure that a resident was protected from verbal abuse.

For the purposes of the definition of abuse subsection 2(1) of the Act "verbal abuse" means 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.

On a specified date a staff member was verbally abusive with a resident who was demonstrating responsive behaviours. The resident's behaviours increased as a result of the incident.

Sources: Interview with a resident; the home’s investigation records; resident's progress notes; interviews with staff. [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 related to s.19 (1) to ensure all resident's are protected against abuse., to be implemented voluntarily.

WN #2: 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 used a safe transferring technique which contributed to a resident's fall.

A resident was found on the floor by staff in distress. Staff were directed to use a mechanical device to safely transfer the resident. The staff used the incorrect device, which required the resident to weight bear. The resident fell and it was later determined they had a sustained an injury.

There was actual harm to the resident by staff not using the proper transfer/lift.

Sources: Resident's progress notes, the home's lift and transfer policy and staff training (2016) and interviews with the staff. [s. 36.]

Issued on this 13th day of October, 2020

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

Original report signed by the inspector.