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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2016	2016_263524_0016	008645-16	Complaint

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

McGARRELL PLACE
355 McGarrell Drive LONDON ON N6G 0B1

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

INA REYNOLDS (524)

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): May 11, 12, 2016.

This complaint inspection is related to allegation of resident neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, two Personal Support Workers and one Housekeeping Aide.

The Inspector also reviewed the Infoline complaint, resident clinical records, the home's internal investigation notes, and policies and procedures related to this inspection.

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)**
- **2 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. 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 neglect by the licensee or staff in the home.

A complaint was reported to the Ministry of Health and Long Term Care Infoline regarding a concern that an identified resident was left on a device unattended while strapped to a personal assistive device, with no call bell within reach for a lengthy period of time on a specified date.

Review of the progress notes and the home’s investigation notes into the incident revealed the following:
- On a specified date, two personal support workers had placed the resident on a device and failed to verbally report to the oncoming shift that the resident was on the device at the end of their shift. In an interview, both staff members stated they had assisted the resident on the device, had placed the call bell so that it could be reached and then carried on with other duties. The Personal Support Workers indicated that the resident had not called by the end of the shift.
-In an interview, it was reported by a Registered Practical Nurse and a Personal Support Worker that they did not enter the resident’s room as the resident told them they did not wish to be disturbed.
-On a specified date and time, a Personal Support Worker went into the resident’s room and reported that the resident was found on the device and still attached to the personal assistive device.
-The identified resident reported that they tried to reach for the call-bell but was unable to reach it due to the call-bell hanging straight down against the wall and stuck between "a box".

Review of the progress notes and investigation notes revealed the resident sustained physical markings as a result of being left on the device for a lengthy period of time.

Record review of the most recent plan of care on PointClickCare (PCC) for the resident revealed the resident was dependent on staff for personal care needs. In addition, the plan of care directed staff to ensure the call bell was within reach and to maintain privacy when using the device but to stay in the immediate area. The care plan did not reflect the resident’s wishes not to be disturbed throughout the identified period of time.

Review of the home’s "Resident Non-Abuse - Ontario" policy #LP-C-20-ON dated September 2014, defined neglect as a failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date, an identified resident was assisted onto a device. The resident was neglected when staff failed to return to assist the resident, who was dependent on staff for all their personal care needs. For an extended period of time, the resident remained unattended on the device, which resulted in physical markings and putting the resident's health and safety at risk.

The licensee failed to protect the resident from neglect by the licensee or staff in the home. [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 are protected from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure any person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A complaint was reported to the Ministry of Health and Long Term Care Infoline regarding a concern that an identified resident was left on a device unattended and strapped to a personal assistive device, with no call bell within reach, for a lengthy period of time on a specified date. No safety checks were completed by staff during that time for the identified resident.

Record review of the progress notes and the home’s internal investigation notes revealed that on a specified date, for an extended period of time, the resident remained on a device strapped to a personal assistive device, causing pressure on the resident's skin and putting the resident's health and safety at risk. The Administrator initiated an investigation immediately upon hearing of the incident and actions were taken in response to the incident. Review of the Critical Incident System used to report incidents to the Director, failed to identify a report related to the identified incident.

The Executive Director and Director of Care agreed that the incident had not been reported immediately to the Director. [s. 24. (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 any 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: Neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

Issued on this 21st day of June, 2016

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

Original report signed by the inspector.