



**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 rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2016	2016_294623_0027	022917-16, 023310-16, 027121-16	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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): September 6, 7, 8, 9, 12 and 13, 2016

The following were concurrently completed during this inspection:

Log#023310-16 - related to maintenance services, food quality and call system response time.

Log#022917-16 - related to allegation of improper treatment.

Log#027121-16 - related to infection control.

Log#027569-16 - related to allegation of improper treatment.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Director of Care (ADOC), Director of Care, DOC, Executive Director (ED), physician, Food Service Supervisor (FSS), Environmental Service Manager (ESM).

During the course of the inspection, the inspector(s): conducted a walking tour of the home, observed resident dining, and resident care, reviewed clinical records, reviewed menus, food temperature records, minutes to food committee meetings, and food samples. Reviewed maintenance service records, infection control and outbreak management records, and applicable policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Food Quality

Infection Prevention and Control

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).



- 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**
- 3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).**
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**
- 5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).**
- 6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).**
- 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**
- 9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).**
- 10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).**
- 11. Every resident has the right to,**
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,**
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**
- 12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).**
- 13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).**
- 14. Every resident has the right to communicate in confidence, receive visitors of**



his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).



- 25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).**
- 26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).**
- 27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).**
- s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs is respected and promoted.

Related to log#022917-16

Resident #002 is a resident of the home with specific identified diagnosis.

During an interview resident #002 indicated that the day of admission to the home he/she was given a shower. Resident stated that the PSW's came and undressed the bottom half of the residents body in the bedroom and then transported the resident down the hallway wearing nothing but a t-shirt. Resident #002 stated that the nurse handled him/her "like a piece of meat" in the shower and said "this is how we do things here". Resident #002 was tearful as the incident was re-told to the inspector. Resident #002 stated that this was reported to the nurse and the resident's daughter, and that the DOC came to speak to about what happened. Resident #002 stated that the PSW who provided the shower to him/her has not taken care of him/her since. Resident #002 stated that this same situation has never happened to him/her again.

RPN#104 confirmed that resident #002 reported the incident on an identified date to the nurse. The RPN confirmed the alleged incident was reported immediately to the DOC and ADOC. RPN#104 indicated that resident #002 continues to be tearful and will occasionally mention the incident.



Review of the licensee's records confirms that the home conducted an internal investigation for the alleged incident and could not determine if resident#002's privacy was respected during the provision of the bath.

Related to log# 027569-16

Resident #003 is a resident of the home with specific identified diagnosis.

On September 6, 2016 PSW#105 was observed by the inspector, transporting resident #003 on a commode chair pulling the resident backwards across the hall from his/her bedroom to the shower room. Resident#003 had a gown on the top half and it was stretched over the front of the knees. From the waist down the resident was bare and his/her bottom was exposed. This observation by the inspector was immediately reported to the ED.

During an interview the Executive Director (ED) indicated that PSW#105 has remained off work pending investigation of the reported incident. During an interview with the inspector, PSW#105 indicated that he/she was not aware that it was wrong to take a resident to the shower down the hallway seated on a commode chair with only the top half of their body covered. PSW#105 indicated that they have never received training related to resident dignity specifically. ED confirmed that the training records for the home reveal that PSW#105 has received training related to Resident's Bill of Rights and Resident non-abuse program in 2015 and 2016.

Therefore, the licensee failed to ensure that resident's #002 and #003 right to be afforded privacy in treatment and in caring for his or her personal needs is respected and promoted related to bathing and personal care. [s. 3. (1) 8.]



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Issued on this 7th day of October, 2016

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

Original report signed by the inspector.