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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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 22, 2014	2014_193599_0012	O-001000-14	Resident Quality Inspection

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

FENELON COURT
44 WYCHWOOD CRESCENT, FENELON FALLS, ON, K0M-1N0

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

HUMPHREY JACQUES (599), MATTHEW STICCA (553), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 6-10 and 14-17 2014

Complaint inspection O-000508-14, Critical incidents logs O-000566-14/432; O-0001059-13. O-000411-13; O-00099-13; O-00090-13 were completed in conjunction with the RQI

During the course of the inspection, the inspector(s) spoke with Residents, family members, the Executive Director, the Director of Care, the Food Service Manager, the Program Manager/ staff educator, the Office Manager, the RAI-MDS back-up, the President of the Residents' Council, the Family Council's Lead, several personal support workers (PSW), several housekeeping aides,dietary aide, Registered nurses (RN), registered practical nurses (RPN)and maintenance staff

During the course of the inspection, the inspector(s) reviewed health care records, reviewed the home's policy and procedures, toured residents' room, residents common areas and service area, reviewed Residents' Council minutes and Family Council minutes, observed one medication pass, observed one lunch meal service and one snack pass, observed the delivery of care and services and staff -resident interaction.Correspondence with the Centralized Intake, Assessment and triage Team. (CIATT)

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 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 that an incident involving Staff #116 who was alleged to have neglected Resident #24 was immediately reported to the Director.Log # O-000411-13
#2850-000007-13 occurred on a specified day in April, 2013, this CIR indicated that during a dinner service Resident #24 requested additional assistance in finishing a portion of their meal as Resident #24 was fatigued and unable to finish eating without assistance. Staff #116 responded to Resident #24 by saying "I don't have time for that". Staff #116 then left the dinning area and Resident #24 did not receive any additional assistance to finish their meal. Staff #105 and #113 reported this to the Program Manager who then reported this to the Executive Director (ED). According to the CIR the MOHLTC was first made aware of this incident six days later.

During an interview with the ED on October 15, 2014, it was disclosed that they did not notify the Director immediately and that the first time the MOHLTC was made aware was in fact six days later.

This information was confirmed in correspondence with MOHLTC Administrative Assistant who has access to SAC reports as well as CIATT Triage Inspector. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that sexual abuse of a resident by anyone that resulted in harm or risk of harm occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. [Log# O-001059-13]

A review of Resident #44's progress notes and the home's Risk Management Incident Form by Inspector #549 indicate that in October, 2013 Resident #44 was observed by PSW # 118 touching Resident #25 inappropriately.

During an interview on October 16, 2014 with PSW # 118 it was confirmed with Inspector #549 that Resident #44 was observed touching Resident #25 inappropriately.

CIATT was contacted by Inspector #549; there are no records that the Director was immediately notified of the alleged sexual abuse of Resident #25.

During an interview with the Executive Director on October 15, 2014 it was indicted to Inspector #549 that the Executive Director was informed immediately of this incident and the home has no record of the immediate notification to the Director of the alleged sexual abuse of Resident #25.

Resident #44 was observed touching Resident #25 inappropriately in October, 2013; the Director was notified by the home of the suspected sexual abuse in November, 2013 using the Ministry of Health and Long Term Care Critical Incident Reporting System. The home did not immediately notify the Director of the suspected sexual abuse of Resident # 25. [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 the Licensee shall ensure that any person who has reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff have occurred, shall immediately report the suspicion and information to the Director, to be implemented voluntarily.

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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later that one business day after a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. [Log # O-00099-13]

A review of Resident # 46's progress notes in December, 2013 indicate that staff were unable to locate Resident #46 in the home at approximately 18:00hrs. Staff immediately began a search for the resident and was found in the secured garden. The mag lock leading to the secured garden was on by pass and allowed the resident

to go out unnoticed. Resident #46 did not sustain any injuries or ill effects from being outside.

During an interview on October 16, 2014 with the Executive Director and the Director of Care it was indicated that Resident #46 was outside alone in the secured garden for approximately half an hour to forty five minutes.

During an interview with the Executive Director on October 14, 2014 it was indicated to Inspector #549 that the home does not have any record of the Director being notified within one business day of Resident #46 missing for less than three hours.

Resident #46 went missing for less that three hours in December, 2013; the Director was notified by the home on December 10, 2013 using the Ministry of Health and Long Term Care Critical Incident Reporting System which is more than one business day after the occurrence of the incident. [s. 107. (3) 1.]

2. The licensee has failed to comply with O.Reg 79/10.S.107(3), whereby the licensee did not ensure that an injury of person that resulted in transfer to hospital was reported within one business day to the Director. [Log #O-000090-13]

Inspector #549 interviewed PSW #109 on October 9, 2014. PSW #109 indicated that in January, 2013, she went into Resident #45's room to inquire if the resident would like to come to the dining room for lunch. Resident #45 stated to PSW #109 "he would prefer to stay in his room and go to bed". PSW # 109 indicated that she then left the resident's room and walked towards the dining room when she heard a loud noise and someone yelling.

PSW #109 indicated that she immediately went down the hallway to Resident #45's room and found the resident lying on the floor. PSW #109 indicated that the Registered Nurse was called, an assessment was completed by the Registered Nurse and Resident #45 was then transported to hospital for further investigation.

A review of Resident #45's electronic progress notes indicated that the resident sustained a fracture and returned from the Hospital to Fenelon Court in January, 2013. The transfer documentation from the Hospital indicated that Resident #45 is not a candidate for surgery.

During an interview with the Executive Director on October 10, 2014 it was indicated

to Inspector #549 that the home has no record of the Director being notified of within one business day of an injury that resulted in transfer to hospital.

CIATT was contacted by Inspector #549 on October 10, 2014; there are no records of the Director being notified within one business day of Resident #45's injury that resulted in transfer to hospital.

Resident #45 had an incident that caused an injury for which the resident was taken to hospital in January 2013; the Director was notified five days later by the home using the Ministry of Health and Long Term Care Critical Incident Reporting System which is more than one business day after the occurrence of the incident.

It is noted, that O.Reg 79/10.s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107(3) was applied.[s.107.(3.1) [s. 107. (3) 4.]

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 the Licensee shall ensure that the Director is informed no later than one business day after the occurrence of an injury to a resident that results in transfer to hospital, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [Log# O-000099-13]

A review of Resident #46's progress notes by Inspector #549 indicated that in December, 2012 the resident could not be located at 18:00hrs. The staff immediately started a search for the resident. Resident #46 was found approximately thirty to forty five minutes later unsupervised outside in the secured garden unable to get back into the home.

The Critical Incident report dated December, 2012 indicated that the mag lock to the secured garden was left on bypass enabling Resident #46 to go outside unsupervised.

During a discussion with the Executive Director on October 16, 2014 Inspector #549 was given a copy of the home's written policy related to door alarms. The written policy titled Safety, was approved by an Administrator, dated December 2001, LTC P 100. A review of the written policy by Inspector #549 indicated that the policy did not include the issue of when doors leading to secure areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

It was confirmed by the Executive Director on October 16, 2014 that the written policy in effect at the time of the incident related to Resident #46 was the one dated December 2001, titled Safety, LTC P 100.

The Executive Director stated after the incident with Resident #46 in December, 2012 the written policy titled Safety was reviewed and updated to include the issue of when doors leading to secured areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The written policy related to door alarms titled Safety ,LTC P 100 dated December 2001 which was in effect at the time when Resident #46 went missing from the home did not include the issue of when doors leading to secure areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [s. 9. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is given to concerns or recommendations made by the Residents' Council within 10 days of receiving the advice.

The Program Manager, assistant to the Residents' Council stated that one of the Managers was not responding in a timely manner to the Residents' Council concerns or recommendation and there was not a written response from the Licensee. President of the Residents' Council, stated that he has been participating in the Residents' Council for over eleven years and the council was not always presented with a written response within 10 days.

The Residents' Council concerns form dated December 24, 2013, indicated that the light outside the main entrance was not lit and this concern was brought forward at the October, November and December meetings.On January 29, 2014, it was noted that the light was still out.
The Residents' Council concerns form dated January 29, 2014, indicated that concerns from residents about small maintenance issues were taking too long to complete; Hand sanitizer between the visitors washrooms was not maintained as these were regularly out of solution; and snow removal on weekdays was not completed in a timely manner. There was no written response from the Licensee to any of these concerns.

In an interview, the Executive Director confirmed that there was not a written response from the Licensee to the concerns from the Residents' Council within 10 days of receiving the advice.
[LTCHA 2007, c. 8, s. 57 (2)] [s. 57. (2)]

Issued on this 24th day of October, 2014

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