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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 26, 2015	2015_195166_0023	O-002651-15	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

CAROLINE TOMPKINS (166), BAIYE OROCK (624), KARYN WOOD (601), LYNDA BROWN (111), SARAH GILLIS (623)

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, 7, 8, 9, 13, 14, 15, 16, 2015

Complaint Log O-001222-14 and Critical Incident Logs, O-001303-14, O-001390-14, O-001919-15 and O-001983-15 were inspected concurrently with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Residents' Council, Family Council representative, Executive Director, Director of Care, Housekeeping staff, Food Service staff, Personal Support Workers, Registered Nurses, Registered Practical Nurses, Office Manager and Program Manager.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. Related to Log O-001390-14

The licensee has failed to ensure that the Director was notified immediately of the suspicion of abuse/neglect of a resident by a staff member.

On an identified date the Executive Director (ED) received a written document submitted by S#116, related to allegations of abuse/neglect of two residents by a staff member over a one month period.

The Director was not notified of the alleged abuse until after business hours the day after the concern was received. [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 that 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. 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Related to Log O-001303-14

The licensee has failed to ensure compliance with its Policy: Home's Leadership & Partnership Manual, Section-Risk Management, Subject - Resident Non-Abuse -Ontario.

On an identified date, Critical Incident Report(CIR) was received reporting incidents of staff to resident(s) verbal abuse that allegedly occurred several days prior to the incident report.

The CIR indicated that S#114 was verbally abusive to Resident #14 and verbally abusive to Resident #16 during the provision of evening care on an identified date.

Review of the licensee's investigation and interview with the ED indicated that Staff #113

and S#114 were providing care to Resident #14 when S#114 made an inappropriate and demeaning comment directed towards the resident.

Review of the licensee's investigation and interview with the ED indicated:
That on an identified date, S#113 reported that S#114 was rushing Resident #16 and the resident became upset when #S114 started to swear at the resident.

In an interview with the DOC and ED, both reported that they became aware of the incident when they received a written document from S#113 concerning the incidents that had occurred a week prior.

S#113 did not immediately report the allegations of abuse to RN on duty/senior manager as per the licensee's policy related to mandatory reporting.

Related to Log O-001390-14

On an identified date, an after hours, Critical Incident Report (CIR)was received reporting that S#116 had submitted a document indicating that for over a month S#116 had concerns about S#122's care practices related to Resident #23 and Resident #45.

The allegations of abuse in the CIR and the licensee's investigation documentation indicated that S#122:
- placed a plate of food in front of Resident #45 and walked away, without addressing and reassuring the resident that assistance would be provided.
-review of the CIR and the licensee's investigation documentation indicated that on an identified date, S#122 was overheard discussing the resident care assignment/ workload in the presence of Resident #23, causing the Resident #23 to become extremely agitated.

-review of the CIR and the licensee's investigation documentation indicated that on an identified date S#122 was observed standing in front of Resident #45, with arms crossed and foot tapping while the resident was being provided care, indicating the resident was taking too long to complete a task.
S#122 was observed eye rolling and was heard saying over the resident, what a waste of time.

S#116 did not immediately report the allegations of abuse to the RN on duty/ senior manager as per the licensee's policy related to mandatory reporting. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Over a five day period, Resident # 29 and Resident # 32's mobility aids were observed to be heavily soiled.

Interview of S#106 & #107 indicated the cleaning of mobility aides is completed by the night shift PSWs and are to be completed on the resident bath days.

Interview of S#104 & #105 indicated the cleaning of mobility aides is completed by PSW night staff who are responsible for cleaning all of resident personal care equipment (wheelchairs, walkers, wash basins, denture cups, etc) on the resident's bath days and then sign off on Point of Care (POC) that it has been completed.
There was no documented evidence that indicated the mobility aides for Resident #29 and Resident #32 were cleaned in the month of September 2015 or to the date of this inspection.

Review of the home's policy "Cleaning/Disinfecting/Sterilizing Resident Equipment" (IPC-C-10) revised March 2014, indicated on page 4/5, under #8: Clean/disinfect resident equipment/items according to the frequency outlined in the Cleaning and Disinfection of Re-useable Non-critical Resident Equipment/Items Procedure [IPC-C-10-05]. Review of the IPC-C-10-05 policy indicated ambulation aid (walkers) are to be cleaned "monthly at a minimum or if soiled". The policy included a "Monthly Resident Equipment Cleaning Record" and a "Weekly Resident Equipment Cleaning Record" .

Interview of Executive Director indicated that the cleaning of mobility aids is completed by night staff Personal Support Workers and signed off on "Cleaning Documentation" form which is not the form indicated in the home's policy.

Review of the plan of care for Resident # 29 & 32 indicated both residents use an aid for mobility and receive two baths /week.
There was no documented evidence the mobility aids are to be cleaned on bath days and no documented evidence of cleaning of Resident #29 and #32's mobility aids by night shift. [s. 87. (2) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Log O-001390-14

The licensee has failed to ensure that Resident #45's Substitute Decision Maker was notified within 12 hours upon becoming aware of an alleged incident of staff to resident abuse.
On an identified date, an after hours, Critical Incident Report (CIR) was received reporting that S#116 had submitted a written document indicating that for over a month S#116 had concerns about S#122's care practices related to Resident #23 and Resident #45.

The allegations of abuse in the CIR and in the licensee's investigation documentation indicated that S#122:
- placed a plate of food in front of Resident #45 and walked away, without addressing and reassuring the resident that assistance would be provided.

-review of the CIR and the licensee's investigation documentation indicated that on an identified date S#122 was overheard discussing the resident care assignment/ workload in the presence of Resident #23, causing the Resident #23 to become extremely agitated.

-review of the CIR and the licensee's investigation documentation indicated that on an identified date S#122 was observed standing in front of Resident #45, arms crossed and foot tapping while the resident was being provided care, indicating the resident was taking too long to complete the task. S#122 was observed eye rolling and was heard saying over the resident, what a waste of time.

Interview with the Executive Director (ED) indicated that designated contact and or substitute decision maker for Resident #45 was not contacted with regards to the alleged incident of verbal abuse.

Resident #23 at the time of the alleged abuse was his/her own Power of Attorney and did not require a designated contact or Substitute Decision Maker. [s. 97. (1) (b)]

2. The licensee has failed to ensure that SDM for resident #45 was notified of the outcome of the investigation of alleged verbal/neglect abuse by S#122

Interview with the Executive Director and a review of clinical record indicated that the SDM was not notified of the outcome of the licensee's investigation related to the alleged abuse/neglect of Resident #45. [s. 97. (2)]

Issued on this 26th day of October, 2015

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

Original report signed by the inspector.