Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central West District**
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# Original Public Report

**Report Issue Date: January 4, 2023**

**Inspection Number:** 2022-1205-0002

**Inspection Type:**
Complaint
Critical Incident System

**Licensee:** Revera Long Term Care Inc.

**Long Term Care Home and City:** Forest Heights, Kitchener

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| JanetM Evans (659) | Janet Evans Digitally signed by Janet Evans Date: 2023.01.23 16:20:02 -05'00' |

**Additional Inspector(s)**
Kristen Owen (741123)

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 5 -9, 13-16, and 19-20, 2022

The following intake(s) were inspected:

- Intake: #00001322-Resident fall with injury.
- Intake: #00003764-Breakdown of major system
- Intake: #00006701-Alleged neglect of a resident
- Intake: #00007003-Alleged Resident self-harm
- Intake: #00008120- Resident to resident abuse.
- Intake: #00013561-Complaint related to staffing, nutrition, documentation and cleaning
- Intake: #00014753-Resident to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Resident Care and Support Services
Safe and Secure Home

Prevention of Abuse and Neglect
Responsive Behaviours
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Falls Prevention and Management
Staffing, Training and Care Standards

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty to Protect

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from abuse by a co-resident.

O. Reg. 246/22 s. 2 defines sexual abuse as:
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

**Rationale and Summary:**

The resident and co-resident had resided in the same wing of the home.

Prior to admission, the co-resident's family discussed common responsive behaviours the resident had exhibited at home.

Between February and October 2022, the co-resident exhibited responsive behaviours towards co-residents and staff.

(a) In September 2022, the co-resident exhibited responsive behaviours towards a resident. The resident was upset by this incident and said it took several days to get over this.

(b) In November 2022, the resident was watching television when were approached by the co-resident who exhibited responsive behaviours.

Documentation by the Social worker said the resident felt abused and unsafe. The resident told inspector #659 they felt violated.

The Director of Care (DOC) said that they believed the co-resident was targeting the resident with their responsive behaviours.

**Sources:** Critical incident system (CIS) #2707-000035-22 and CIS#2707-000045-22; investigation notes for CIS#2707-000045-22, DOS charting for resident #011, interview with residents #010 and #011, DOC, former ADOC and staff [659]

## WRITTEN NOTIFICATION: Reporting certain matters to the Director

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure allegations regarding abuse of two residents and neglect of one resident were immediately reported to the Director.

**Rationale and Summary:**
(a) In August 2022, the Resident Services Coordinator (RSC) and the Office Manager (OM) received an email from a resident's Power of Attorney (POA), with concerns that the resident was not provided assistance to get up for four hours and were not provided with the appropriate level of care.

The home did not report this to the Director until the following day. The DOC confirmed this should have been reported immediately.

Delays in reporting to the Director could prevent the Director from intervening, if necessary.

**Sources:** CI # 2707-00031-22, inquiry with previous ADOC #125 completed by inspector #729, and interview with the DOC.
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(b) In October 2022, a resident was observed to exhibit sexual responsive behaviours towards a co-resident.

An RN working at the time of the incident said they notified management about the incident.

The incident was not reported to the Director.

Failing to report to the Director could prevent the Director from intervening, if necessary.

**Sources:** progress notes, policy: Mandatory reporting of resident abuse or neglect, ADMIN-010.01, reviewed March 31, 2022. Resident non abuse program, ADMIN1-P10-ENT, reviewed March 31, 2022. Interviews with DOC, RN #140
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(c) In Feb 2022, a resident was observed interacting with a co-resident in an intimate manner by the nursing station. The co-resident told the resident to stop. The resident did not stop until a student nurse intervened and separated the residents.

A summary note documented that the ADOC was notified of the incident.

The incident was not reported to the Director.

Failing to report to the Director could prevent the Director from intervening, if necessary.

**Sources:** progress notes, policy: Mandatory reporting of resident abuse or neglect, ADMIN-010.01, reviewed March 31, 2022. Resident non-abuse program, ADMIN1-P10-ENT, reviewed March 31, 2022. Interviews with DOC #101, former ADOC #125, RN #140.
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## WRITTEN NOTIFICATION: Policy to promote zero tolerance

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents, was complied with. Specifically, the licensee failed to ensure staff complied with the home's policy and procedures related to investigations of alleged abuse or neglect. As well, staff did not comply with the home's procedures for disciplinary action for abuse or neglect, both of which were included in the licensee's "Resident Non-Abuse Program" policy.

**Rationale and Summary:**

(a) A critical incident #2707-000035-22 alleging abuse of a resident by a co-resident was submitted to the Ministry of Long Term Care (MLTC).

The home's resident non abuse policy documented their standards and referenced the location of procedures to be followed related to mandatory reporting, investigations, disciplinary actions, interventions for victims and for analysis and education and documentation.

At the time of the inspection, inspector #659 was provided with a copy of the amended CIS report for CI #2707-000035-22 as the home's investigation file.

Former ADOC #125 said they had been involved in investigating this critical incident. They said they had very casual notes in a notebook of theirs and they had removed the notebook from the home. They acknowledged there was no other investigation notes in the home.

DOC #101 said a thorough investigation meant meeting with persons involved, interviewing witnesses, following the policy for who to report to, and notifying the family and the MLTC. Their process for completing and documenting an investigation included having two managers conduct interviews. Ideally it would all be documented and include the date, time, and name of attendees. Documentation would be entered and saved into their public drive. A copy would be put in their CI binder. Records should not be removed from the home, they should be locked in the ED or DOC's office.

Failure to follow the home's policy for abuse investigations may risk that an investigation is not completed or documentation of investigations cannot be located.

**Sources:** Critical incidents 2707-000035-22 and 2707-000045-22, policies Resident Non-Abuse Program, ADMIN1-P10-ENT, reviewed March 31, 2022, LTC-Investigation of Abuse or Neglect, ADMIN1-0101.02, Resident Non-Abuse Toolkit for conducting and alleged abuse investigation: Nov 2010, interviews with DOC #101 and former ADOC #125

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(b) In August 2022, the home received an email from a resident's POA with concerns that a specified resident had been neglected by staff. The home initiated an investigation the day following receipt of the email.

The home's procedure for disciplinary action stated if a staff member of a Revera home was alleged, suspected, or witnessed to have abused and/or neglected a resident, that staff member will be put on administrative leave with pay and will be required to leave the premises immediately, pending investigation.

The previous ADOC #125, acknowledged the PSW allegedly involved in the incident was not removed from working at the home while the investigation occurred. The DOC confirmed the PSW continued to

care for the resident following the allegations, and the LTCH's investigation notes showed the PSW was not interviewed until five days following the initiation of the investigation.

Allowing the PSW to continue to care for the resident while the investigation into the alleged neglect was ongoing, posed a risk to the resident if the allegation were founded.

**Sources**: CI #2707-000031-22, inquiry with previous ADOC #125 completed by inspector #729, resident #002's Follow-Up Question Report, Revera Policy – Resident Non-Abuse Program, section: Resident Non-Abuse, index: ADMIN1-P10-ENT, effective date: LTC-August 31, 2016, reviewed date: March 31, 2022, Revera Procedure – LTC-Disciplinary Action for Abuse and Neglect, section: Resident Non-Abuse, index: ADMIN1-O10.03, manual: administration, effective date: August 31, 2016, reviewed date: March 31, 2022, and interviews with the DOC.

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## WRITTEN NOTIFICATION: Behaviours and altercations

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions which were developed to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours; and to minimize the risk of altercations and potentially harmful interactions between and among residents, were implemented.

**Rationale and Summary:**

A resident's progress notes from February 2022 to December 2022 document the resident exhibited numerous responsive behaviours towards co-residents and staff.

Their plan of care included multiple interventions to manage the behaviours.

In December 2022 :

-The resident was to have constant monitoring to deter responsive behaviours. The resident exhibited responsive behaviours towards a PSW when the person who was to be monitoring them was not present with them.

-The staff monitoring the resident was to ensure the resident within their sightlines, but they were observed walking with their back to the resident leaving the resident to follow along behind them.

-Devices were not engaged across room doors to prevent the resident from wandering. Staff were also uncertain about the purpose of the devices.

- A PSW said they provided care to the resident alone, despite their awareness that the resident was to have two staff provide care.

Failure to implement the interventions for the resident, from their behavioural plan of care put residents and staff at risk of harm from the resident.

**Sources:** observations, Critical incident system (CIS) #2707-000035-22 and CIS #2707-000045-22 , plan of care, progress notes, interviews with resident and staff.

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## WRITTEN NOTIFICATION: Food and Nutrition Program

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

The licensee failed to ensure that staff complied with the home's tray service guidelines.

In accordance with O. Reg 246/22 s. 11. (1) (b), the licensee shall ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the home's LTC Tray Service Guidelines for meals (undated), which was included in the licensee's Nutrition and Hydration program.

**Rationale and Summary:**

A complaint to the MLTC alleged residents were left in their room for breakfast and not being fed, but records were falsified to document the residents were fed.

The home's procedure for tray service included that residents who would receive permanent tray service must have the requirement and the need documented within their plan of care. If temporary tray service was requested, a request form be completed by the PSW, verified by registered staff and submitted to culinary department where it would be retained on file as per documentation records.

Observations of the dining room on one home area on two days in December 2022, showed that all residents had not attended the dining room for breakfast.

Two Dietary Aides said tray service had been provided to residents who had not attended the dining room but were unable to account for the actual number of trays provided to residents in their rooms.

The Dietary Aides, a PSW and an RN said there used to be a form that was signed with the PSW and nurse to track tray service, but they did not have this now. The RN was unable to account for the number of residents who received a breakfast meal in the dining room or tray service.

The nutrition manager acknowledged there was no recent documentation related to tray service for Hewson House.

The ED said residents were offered 3 meals per day and this was documented and tracked on Point Click Care. They said their numbers on tray service were quite high and related this to outbreaks. At the time of observations, the unit was not in an outbreak.

When staff did not follow the home's guidelines for tray services, it placed the residents at risk of not receiving tray service for their breakfast meal or missing meals.

Sources: observations, LTC Tray Service Guidelines for meals, interviews with staff and residents.

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## WRITTEN NOTIFICATION: Personal Items and Personal Aids

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 41 (1) (b)

The licensee failed to ensure that that residents' personal aids were cleaned as required. Specifically, the licensee failed to ensure residents' wheelchairs were clean.

**Rationale and Summary:**

A complaint to the MLTC alleged wheelchairs had not been cleaned in a year.

On two days in December 2022, observations of wheelchairs on two home areas showed several wheelchairs on these units were soiled.

A Resident Equipment Cleaning and Storage Audit completed December 8, 2022, for one home area documented that the wheelchairs and cushions were dirty. No specific wheelchairs were identified.

The Revera procedure for cleaning and disinfecting of specific non-critical reusable resident equipment items directed staff that ambulation aids were recommended to be cleaned monthly at minimum or if soiled. Staff were to wipe or apply approved disinfectant.

Two PSWs observed wheelchairs for residents on the two home areas and acknowledged they were not clean. The staff stated wheelchair cleaning was to be done on night shift by PSWs.

The DOC said that they knew there had been gaps related to the cleaning of the wheelchairs.

Failing to clean and disinfect ambulation aids could potentially risk infectious organisms being transmitted through the home.

**Sources:** Observations, Complaint, Kardex, POC task history, Cleaning & Disinfecting of Specific Non-Critical Reusable Resident Equipment/Items, Huddles for February and September 2022, interviews with Administrator, DOC and staff.

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