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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2018	2018_674610_0009	000978-16, 016859-16, 020180-16, 023992-16, 028021-16, 029337-16, 029981-16, 031468-16, 016983-17, 017131-17, 017560-17, 017879-17, 024780-17	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Hillside Manor
Highway 8, 5066 Perth E. Line 34, R. R. #5 STRATFORD ON N5A 6S6

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

NATALIE MORONEY (610), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 6, 7, 8, 11, 12, 13, 14, and 15, 2018

The following intakes were inspected concurrently:

Log #017560-17 Critical Incident #1975-000015-17 related to alleged staff to resident abuse.
Log #016983-17 Critical Incident #1975-000012-17 related to alleged staff to resident abuse.
Log #016859-16 Critical Incident #1975-000007-16 related to alleged resident to resident abuse.
Log #017879-17 Critical Incident #1975-000016-17 related to alleged staff to resident abuse.
Log #023992-16 Critical Incident #1975-000012-16 related to alleged resident to resident abuse.
Log #020180-16 Critical Incident #1975-000009-16 related to alleged staff to resident abuse.
Log #029337-16 Critical Incident #1975-000017-16 related to alleged staff to resident abuse.
Log #000978-16 Critical Incident #1975-000001-16 related to alleged resident to resident abuse.
Log #028021-16 Critical Incident #1975-000015-16 related to alleged resident to resident abuse.
Log #029981-16 Critical Incident #1975-000026-17 related to alleged staff to resident abuse.
Log #031468-16 Critical Incident #1975-000020-16 related to alleged family to resident abuse.
Log #017131-17 Critical Incident #1975-000014-17 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care, the Staff Educator, the Resident Assessment
Instrument Coordinator, the Regional Director of Operations, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspector(s) also made observations of residents care and staff to resident interactions. Relevant policies and procedures, as well as reviewed clinical records and plans of care for identified residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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. 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. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A) The home submitted to the Ministry of Health and Long Term Care (MOHLTC) Critical Incident (CIS) report related to resident to resident alleged abuse.

A review of a specific resident's progress notes indicated that a staff member witnessed abuse did not report immediately to their Director of Care (DOC) or the Manager on call. The home submitted to the MOHLTC a CIS report related to resident to resident alleged abuse.

A review of resident's progress notes indicated that a staff member witnessed the abuse and this was not reported immediately to their Director of Care (DOC) or Manager on call.

During interviews the Associate Director of Care and the Education Coordinator both stated that if staff witnessed or suspected abuse they would report it immediately to their Director of Care (DOC) or Manager on call.

During an interview, Executive Director stated that the alleged abuse was not reported by staff immediately and that the expectation was that staff report immediately abuse or suspicion of abuse to their manager. [s. 20. (1)]

B) The home submitted to the MOHLTC a CIS report related to alleged abuse.

A review of a specific resident documentation indicated that the resident had reported the abuse to a staff member and this was not reported immediately to their Director of Care (DOC) or Manager on call.

During interviews the Associate Director of Care and the Education Coordinator both stated that if staff witnessed or suspected abuse they would report it immediately to their Director of Care (DOC) or Manager on call.

During an interview, Executive Director stated that the alleged abuse was not reported by staff immediately and that the expectation was that staff report immediately abuse or suspicion of abuse to their manager. [s. 20. (1)]

C) The home submitted to the MOHLTC Critical Incident (CIS) report related to staff member to resident alleged abuse.

A review of resident's progress notes indicated that a staff member witnessed the alleged abuse and this was not reported immediately to their Director of Care (DOC) or Manager on call.

During interviews the Associate Director of Care and the Education Coordinator both stated that if staff witnessed or suspected abuse they would report it immediately to their Director of Care (DOC) or the Manager on call.

During an interview, the Executive Director stated that the alleged abuse was not reported by staff immediately and that the expectation was that staff report immediately abuse or suspicion of abuse to their manager. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, 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 that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm

A) The Ministry of Health and Long Term Care (MOHLTC) received a Critical Incident (CIS) Report, related to allegation of abuse from one resident to another resident.

"Sexual Abuse" is defined in Ontario Regulation 79/10 as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by the licensee or a staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or a staff member".

The homes policy stated in part that an immediate report to the Director of the Ministry of Health and Long Term Care if there was a reasonable suspicion that abuse or neglect occurred or may occur as well as the details to support the suspicion and that this would

apply to the abuse of a resident by anyone or neglect of a resident by the licensee or the staff that resulted in harm or a risk of harm to the resident.

Further review documentation showed that a specific resident allegedly abused another resident and that the nurse had reported the incident to the manager, however there was no internal investigation completed and no completed CIS report submitted to the MOHLTC.

An officer had contacted the MOHLTC on-call service and showed that a specific resident had allegedly abused another resident There was no completed CIS report submitted by the home to the Director regarding this incident however documentation showed that the family, medical doctor and police were notified.

During interviews Associate Director of Care and Education Coordinator both stated that if staff witnessed or suspected abuse they would report it immediately to their Director of Care (DOC) or Manager on call.

The Executive Director said that the home should have completed an internal investigation related to all allegations of abuse and that those incidents should have been reported immediately to the Director of the MOHLTC.

The licensee failed to ensure that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm was immediately report the suspicion and the information upon which it was based to the Director.

B) The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; that Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was reported immediately to the Director of the MOHLTC.

1. The MOHLTC received a CIS report for a specific resident that was injured during resident care and resulted in a significant change in status. The home had not immediately report the improper care to the Director immediately.

2.The MOHLTC received a CIS report that showed that another specific resident was injured during care, and the home did not report the improper care immediately to the Director.

During interviews the Associate Director of Care and Education Coordinator both stated that if staff witnessed or suspected abuse they would report it immediately to their Director of Care (DOC) or Manager on call.

The Executive Director said that the home should have reported immediately to the Director of the MOHLTC regarding the improper care of the specific resident's.

The licensee failed to ensure that Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was reported immediately to the Director of the MOHLTC [s. 24. (1) 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 the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm and to ensure that Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident is reported immediately to the Director of the MOHLTC, to be implemented voluntarily.

WN #3: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that where an incident occurred that had caused an injury to a resident for which the resident was taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

The MOHLTC received a CIS report submitted from the home for a specific resident who had an injury. The resident was transferred to hospital and had a significant change in status.

Documentation showed that a staff member from the home had spoken with the hospital and confirmed that the resident had a change in health status.

The Executive Director said that the home should have reported to the Director of the MOHLTC, when the home first became aware that resident had a significant change to the resident's health condition.

The licensee failed to determine if the resident that had a significant change in the resident's health condition and they did not inform the Director of the incident no later than three business days. [s. 107. (3.1)]

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 where an incident has occurred that has caused an injury to a resident for which the resident was taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4), to be implemented voluntarily.

Issued on this 28th day of June, 2018

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

Original report signed by the inspector.