Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2021	2021_778563_0007	002377-21, 004104-21	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 East Line 34, R.R. #5 Stratford ON N5A 6S6

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

MELANIE NORTHEY (563)

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): April 20 and 21, 2021

The following Critical Incident (CI) intakes were completed within this inspection:
Log #004104-21 / CI #1975-000006-21 related to COVID-19 - Outbreak
Log #002377-21 / CI #1975-000004-21 related to staff to resident suspected abuse

During the course of the inspection, the inspector(s) spoke with the Director of Care, Personal Support Workers, a Housekeeper and a resident.

The inspector conducted a tour of the home and made observations of residents and care. The inspector also observed meal and snack service, resident/staff interactions, infection prevention and control practices and active visitor screening. Relevant policies, procedures and investigation notes were also reviewed.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1.The licensee failed to ensure that the outcomes of resident #001's eating activity of daily care were documented.

There was a Critical Incident System Report submitted to the Ministry of Long-Term Care related to staff to resident #001 suspected abuse. Resident #001 was interviewed and stated they were not receiving specific care and staff were refusing to assist resident #001.

The Point of Care (POC) documentation was reviewed to determine resident performance and staff participation in specific care activities. Personal Support Worker (PSW) #102 completed documentation to indicate resident performance and the staff support provided before the activity happened. Six residents were documented as "independent, no help or oversight" and "no setup or physical help" required from staff.

PSW #102 verified the documentation was completed before the activity occurred for six residents.

The residents' eating activity and staff participation was not documented at the outcome of care. PSW #102 predicted what care would be required and was not present to observe otherwise. Inaccurate documentation of staff participation and resident performance could put the residents at risk for inaccurate care planning related to a specific activity.

Sources: residents' clinical record reviews, resident #001 interview and observations, and staff interviews. [s. 6. (9) 2.]

2. The licensee failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's specific activities of daily living (ADL) needs changed.

There was a Critical Incident System Report submitted to the Ministry of Long-Term care related to staff to resident suspected abuse. Resident #001 was interviewed and stated they required more assistance with specific activities of daily living (ADLs).

The current care plan in Point Click Care (PCC) documented resident #001 required increased staff support.

Personal Support Worker (PSW) #102 verified resident #001 required increased staff support for specific ADLs.

There could be potential for risk when plan of care interventions were not updated to reflect the current increased care needs for resident #001.

Sources: resident #001's clinical record review, resident #001 interview and observations, and staff interviews. [s. 6. (10) (b)]

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 following are documented: the outcomes of the care set out in the plan of care, and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of resident #001 was immediately reported to the Director.

There was a Critical Incident System (CIS) Report submitted to the Ministry of Long-Term Care (MLTC) related to staff to resident suspected abuse. Resident #001 was interviewed and reported that Personal Support Workers (PSW) #104 and #105 were not providing the required care. Resident #001 stated the managers did not believe their reported complaints.

A progress note documented reported complaints from resident #001. The items were reported to Director of Care (DOC) #101 immediately by the writer due to allegations of abuse and neglect and the DOC stated they were already aware of what the resident had said as resident #001 spoke to the DOC.

DOC #101 verified there have been numerous reported complaints from resident #001 related to staff. The DOC verified that there were allegations of abuse and neglect documented as part of resident #001's progress notes and that a CIS Report was not submitted to the Director of the MLTC at the time.

Failure to report all suspected allegations of abuse and neglect and the information upon which it was based to the Director placed the resident at risk. Reporting allegations of suspected abuse to the MLTC would have served to protect the resident.

Sources: Long-Term Care Homes Portal, CIS Report, resident #001’s clinical record review, resident #001 interview, and staff interviews. [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: 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was offered a minimum of three meals daily. O. Reg. 79/10, s. 71 (3).

There was a Critical Incident System Report submitted to the Ministry of Long-Term Care related to staff to resident suspected abuse. Resident #001 was interviewed and stated they were not receiving three meals a day.

Director of Care (DOC) #101 stated resident #001 does not get meals in their room due to the risk of choking. Resident #001 does eat other food items from the snack cart in their room.

The Hillside Manor Resident Care Progress Reports were paper progress notes for Personal Support Workers (PSW) to document interactions with resident #001. A note stated resident #001 was to come to dining room to have their meal.

PSW #105 stated the nursing team decided that if resident #001 wanted dinner the resident had to come to the dining room. PSW #105 stated resident #001 would have dinner every night if someone was feeding the resident in their room.

Resident #001 was at risk of being hungry when they were denied a dinner meal service in their room.

Sources: resident #001’s clinical record review, resident #001 interview and observations, and staff interviews. [s. 71. (3) (a)]

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 each resident is offered a minimum of three meals daily, to be implemented voluntarily.

Issued on this 11th day of May, 2021

[redacted]

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

Original report signed by the inspector.