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

Division de la responsabilisation et de la performance du système de santé
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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
Dec 11, 2015	2015_382596_0016	032852-15	Complaint

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

MACKENZIE PLACE
52 GEORGE STREET NEWMARKET ON L3Y 4V3

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

THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 25, 26, 27 and 30, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), program manager (PM), physiotherapist (PT), York Region Police, registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), housekeeper, family member.

During the course of the inspection, the inspector conducted observations, interviews, reviewed clinical health records, and relevant home policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Record review of a complaint received from MOHLTC Infoline in November 2015 and a Critical Incident indicated that on a specified date, an identified resident's family member notified the home of a suspicion that the resident was abused. Record review of the CI revealed that it was first submitted to MOHLTC by the home six days after the family member notified the home of their suspicion.

Interview with the home's Executive Director (ED) revealed that he/she met with the family member on two consecutive specified dates, then called the MOHLTC after the second meeting with the family member, with notification of an email complaint received from the identified resident's family member on an identified date; he/she also submitted the email complaint. The ED reported that he/she did not identify the resident or give particulars about the allegation of abuse when he/she called in the email complaint, nor was a CI submitted until six days later. [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 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 has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

Record review of the home's policy titled Falls Interventions Risk Management (FIRM) Program #LTC-E-60, revised date March 2014, directs staff to notify the resident's substitute decision maker (SDM)/family after a fall. Record review of an identified resident's progress notes revealed that on a specified date in November 2015, resident was found lying on the floor next to his/her bed after having an unwitnessed fall. A head to toe assessment was completed by an identified registered staff and the resident was transferred to bed; the resident did not sustain any injuries related to the fall. Record review of the resident's progress notes indicated that the resident's SDM/family was not notified after the resident fell on a specified date in November 2015.

Interviews with an identified staff and the DOC confirmed that the home did not notify the resident's SDM after the resident fell in his/her room on a specified date in November 2015. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Record review of an identified resident's progress notes and interviews with identified staff and the DOC revealed that on a specified date in November 2015, resident was found lying on the floor next to his/her bed after having an unwitnessed fall. A head to toe assessment was completed by an identified registered staff and the resident was transferred to bed; the resident did not sustain any injuries related to the fall.

Record review of the identified resident's clinical record and interviews with Physiotherapist (PT) #109 and the DOC confirmed that PT #109 did not reassess the resident post fall and document the interventions and resident's responses to interventions. [s. 30. (2)]

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.