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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 22, 2020 | 2020_792659_0010 | 008129-20, 009901-20, 010506-20, 010941-20 | Complaint |

### 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

Riverbend Place
650 Coronation Blvd. CAMBRIDGE ON N1R 7S6

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

JANETM EVANS (659), KATHERINE ADAMSKI (753)

## 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): June 1, 2, 3 and 4, 2020.**

**Log #008129-20\ IL-77311-CW Complaint related to alleged staff to resident abuse**
**Log# 009901-20\ IL-78125\CI 2753-000012-20 related to resident to resident abuse**
**Log #010506-20\ IL-78465-CW Complaint related to Infection Prevention and Control and Staffing**
**Log #010941-20\ CI 2753-000014-20 related to alleged staff to resident neglect**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Regional Manager/Interim Executive Director (IED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Infection Prevention and Control (IPAC)Lead, Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Ontario lead (BSO), Personal Support Workers (PSW), Physiotherapy Aide (PTA), Housekeepers and residents.**

**The Inspectors toured the home. Observations were made for dining service, provision of care, staffing and activities. Clinical records and relevant documentation for identified residents were reviewed, as well as staff schedules, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #009 was protected from abuse by anyone.

O. Reg. 79/10, defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) related to a resident to resident altercation.

Review of resident #009's progress note documentation for a specified date, showed that resident #009 initially complained of pain following the incident.

PSW #114 said resident #009 had visible signs of injury post incident.

PTA #116 said that on a specified date they witnessed an altercation between resident #009 and #010 in the hall, following which resident #009 complained of pain and seemed dizzy.

Resident #010 said they became physically aggressive with resident #009 as they did not like to be touched.

DOC #100 said resident #010 had known responsive behaviours. The resident had not exhibited these behaviours towards other residents in the past.

The licensee has failed to ensure that resident #009 was protected from abuse by anyone. [s. 19. (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 resident #009 and all other residents are protected from abuse by anyone, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program for resident #002.

The home's procedure for Contact Precautions, IPC2-O10.06, dated March 31, 2019, said that gloves and gown should be worn for direct care.

During observations of the home, inspector #659 noted signage was posted on resident #002's door for contact precautions that advised staff to wear gloves and a gown when providing direct care. There was no Personal Protective Equipment (PPE) at the point of access i.e. no PPE in the immediate vicinity of the resident's room.

The plan of care for resident #002 stated that PPE was to be accessible at the point of care. It stated that gloves were to be worn for all resident/environment contact and that a long sleeve gown was to be used for direct care when skin or clothing may become contaminated.

On June 2, 2020, PSW #105 was observed to provide physical assistance to resident #002 in their room. The PSW was not wearing a gown or gloves.

PSW #105 stated that they were aware of the signage on the resident's door, but they believed the precautions were over. They acknowledged they had not worn the recommended PPE when they assisted resident #002.

IPAC lead #110 said staff should follow the signage on the door for what PPE should be worn when working with a resident who has an infection. The IPAC lead said staff should have at least used gloves when in contact with a resident on contact precautions.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program for resident #002 in that staff did not follow use gloves when providing care assistance to resident #002. [s. 229. (4)]

***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 staff follow the home's IPAC program. Specifically, the home shall ensure that staff follow the posted recommendations for use of PPE when providing direct care to residents, and the home will ensure that PPE is available at the point of care, to be implemented voluntarily.***

---

**WN #3: 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 home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A complaint was received to the Ministry of Long Term Care related to alleged rough handling and verbal abuse of resident #001 by staff.

A review of the home's procedure titled, "LTC - Investigation of Abuse and Neglect" included in the home's Resident Non-Abuse Policy, stated "the priority is to ensure the safety and comfort of the abuse victim(s) by taking steps to provide for their immediate safety and well being, then complete full assessments to determine the resident's needs and document them on the resident's plan of care".

A review of resident #001's plan of care including progress notes, risk management, and assessment's tab showed that no full assessments were completed.

RPN #107, DOC #100 and IED #108 all stated that a resident was to be assessed immediately in response to alleged abuse, however there was no concensus as to the type of assessment(s) to be completed.

IED #108 acknowledged that resident #001 was not assessed in response to this incident.

The licensee failed to ensure that a full assessment of resident #001 was completed and documented on the resident's plan of care. [s. 20. (1)]

---

**Issued on this 24th day of June, 2020**

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

**Original report signed by the inspector.**