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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 20, 2024	
Inspection Number: 2024-1083-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Thorntonview, Oshawa	
Lead Inspector Patricia Mata (571)	**Inspector Digital Signature** Patricia Mata Digitally signed by Patricia Mata Date: 2024.02.22 10:52:19 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7, 8, 2024
The inspection occurred offsite on the following date(s): February 12, 2024

The following critical incidents were inspected:

- ·Intake: #00107423 related to an allegation of physical abuse of a resident by a staff member

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Duty to protect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Develop a written process that ensures when an allegation of staff to resident abuse is substantiated after an investigation, a written plan is put into place to meet regularly with and actively monitor the accused staff member, to prevent further occurrence. A written record should be kept of progressive discipline and measures taken to prevent further occurrences.
2) Conduct a root cause analysis of all allegations of staff to resident abuse resulting in physical or emotional injury and identify mitigation strategies to prevent further occurrence. Keep a documented record of root cause analysis and mitigation strategies.
3) The written process should list actions that may be utilized by Managers to keep residents protected from abuse in the future, including suggestions for monitoring and follow up with staff.
4) Educate all Managers on this process. Keep a written record of this education including who was educated, when and who provided the education.
5) A written copy of the process and education must be immediately available to

inspectors upon request.
6) Any plans put into place for staff members must be immediately available to inspectors upon request.

Grounds

1) The licensee failed to protect resident #001 from abuse by Personal Support Worker (PSW) #101.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted for an allegation of staff to resident verbal abuse. PSW #101 verbally abused resident #001. The incident was witnessed by two staff members.

During the licensee's investigation, the PSW acknowledged that their behaviour was inappropriate but felt that they were justified in their actions. The PSW was disciplined and re-educated.

The Executive Director (ED) indicated that they were concerned that another incident like this could occur but by following the licensee's policy and procedures and investigating right away, it was the only way to hold a staff member accountable. The license did not follow up with the PSW after their investigation nor was a plan put in place to protect residents from future abuse by PSW #101.

By failing to protect residents from abuse by PSW #101, the licensee put residents at risk of abuse.

Sources: Licensee's investigation, CIR, resident's care plan and interview with the

Executive Director. (571)

2. The licensee failed to protect resident #002 from abuse by Personal Support Worker (PSW) #101.

Rationale and Summary:

A CIR was submitted for an allegation of staff to resident physical abuse. Resident #002 reported that PSW #101 had physically abused them causing injuries.

The resident did not report the incident at the time that it had occurred. The incident was reported later that day to Registered Nurse (RN) #105. RN #105 documented the resident's account of the incident. The resident had sustained an injury and stated the PSW had caused it.

RN #105 stated that the resident was capable of knowing what had happened to them.

The licensee's investigation included written statements and interviews. PSW #101 had reported the injury to RN #106 earlier that day. The RN thought the resident had injured themselves.

The Executive Director indicated during their investigation, they reviewed the injury resident #002 sustained, the resident's recounting of the incident and considered that resident #002 was one of the residents that PSW #101 had conflict with in the past. They stated they suspected PSW #101 did harm the resident but did not have the evidence to support the allegation. Therefore, no disciplinary action was taken. The license did not follow up with the PSW after their investigation nor was a plan put in place to protect residents from future abuse by PSW #101.

By failing to protect residents from abuse by PSW #101, the licensee put the residents at risk of abuse.

Sources: Licensee's investigation, CIR, resident #002's health records and interviews with RN #105 and the Executive Director. (571)

3) The licensee failed to protect resident #003 from abuse by PSW #101.

Rationale and Summary:

A CIR was submitted for an allegation of physical abuse of resident #003 by PSW #101. The resident informed RN #107 the PSW injured them.

An investigation was completed by the licensee which included review of video surveillance. PSW #101 was seen willfully causing injury to the resident. The contents of the video did not correspond with the account of the incident given by PSW #101 during the licensee's investigation. The Executive Director stated PSW #101's employment was terminated after the investigation of the incident was concluded.

PSW #101 had previously been accused of abuse towards resident #001, and #002. The licensee failed to protect residents from abuse by PSW #101 after each of these allegations. Therefore, the licensee put resident #003 and other residents at risk of harm or injury.

Sources: Interview with Executive Director, CIR, resident #003's health records, and video of the incident. [571]

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This order must be complied with by April 1, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.