

**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
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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
Dec 11, 2019	2019_739694_0025	016894-19, 018048- 19, 019747-19, 020794-19	Follow up

Licensee/Titulaire de permisRevera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4**Long-Term Care Home/Foyer de soins de longue durée**Trillium Court
550 Philip Place KINCARDINE ON N2Z 3A6**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 13, 15, 19 and 20, 2019.

**During this inspection the following intakes were inspected;
Log #016894-19, follow up to CO #001 from Inspection 2019_798738_0014,
Log #018048-19, a complaint regarding Prevention of Abuse and Neglect,
Log #019747-19, and Log #020794-19, related to Fall Prevention.**

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN) Director of Care (DOC) and the Administrator.

The inspector also toured the home, observed the provision of care, meal and snack service, reviewed resident clinical records, reviewed relevant policies and procedures and interviewed family members, residents and staff.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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

4 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 44. (7)	CO #001	2019_798738_0014	694

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
<p>WN – Written Notification</p> <p>VPC – Voluntary Plan of Correction</p> <p>DR – Director Referral</p> <p>CO – Compliance Order</p> <p>WAO – Work and Activity Order</p>	<p>WN – Avis écrit</p> <p>VPC – Plan de redressement volontaire</p> <p>DR – Aiguillage au directeur</p> <p>CO – Ordre de conformité</p> <p>WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

Findings/Faits saillants :

The licensee failed to ensure that every alleged incident that the licensee knows of, or that is reported is immediately investigated, including abuse of a resident by anyone.

During a follow up inspection, a complaint intake was inspected. A Specific resident and their substitute decision maker (SDM) reported alleged abuse. The incident had occurred the day before and involved a staff member.

The clinical record for the specific resident was reviewed. Documentation indicated that the concern was first reported on a specific date and the DOC met with the resident and SDM the following day. There was no further documentation about the incident.

The home did not provide any record of an investigation.

The licensee failed to ensure that an alleged abuse incident by a staff member, that was reported by a resident and their SDM, was immediately investigated.

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 every alleged incident that the licensee knows of, or that is reported is immediately investigated, including Abuse of a resident by anyone,, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specific date in November, 2019, the LTCH inspector observed residents in the small dining room finishing their meal. A resident was observed to be demonstrating a specific behaviour. The RN and RPN were not in the dining room and could not observe the resident.

The clinical record for the specific resident was reviewed. Responsive behaviours were identified on the resident's care plan, which included the demonstrated behaviour. Staff were to provide supervision when the resident was in the dining room.

The licensee failed to ensure a resident was provided the supervision as set out in the plan of care.

WN #3: 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 :

The licensee failed to ensure that an allegation of 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 was immediately reported to the Director.

A resident and their SDM reported an incident of alleged physical and verbal abuse.

Management acknowledged they did not complete a critical incident system (CIS) report in relation to the incident of alleged abuse.

The licensee failed to ensure that an allegation of abuse of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

A resident and their SDM reported an incident of alleged abuse. The DOC spoke with the resident and SDM the next day.

The home did not have record of a response to the resident or SDM.

The complainant's were not provided with the outcome of the investigation into the incident of alleged staff to resident abuse.

The licensee failed to ensure that a verbal complaint made to a staff member concerning the care of a resident was investigated, resolved where possible, and a response provided to the complainants within 10 business days of receipt of the complaint.

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.