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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2017	2017_597655_0015	009517-17, 011443-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

Long-Term Care Home/Foyer de soins de longue durée

HEARTWOOD
201-11TH STREET EAST CORNWALL ON K6H 2Y6

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

MICHELLE EDWARDS (655)

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): August 3 and August 4, 2017.

During this inspection, the following logs were inspected concurrently:
- Log #0011443-17 (Complaint) related to a concern regarding a residents trust account, continence care, and an allegation of staff-resident verbal abuse and neglect; and,
- Log #009517-17 (Critical Incident) related to an allegation of staff-resident neglect.

During the course of the inspection, the inspector(s) spoke with residents and family, Personal Support Workers (PSWs), Registered Nursing Staff (RNs and RPNs), the Business Manager, the Dietary Manager, the Director of Care (DOC), and the Executive Director (ED).

During the inspection, the Inspector also observed the provision of resident care and services; and, reviewed resident health care records, an "Unfunded Services Agreement", and records related to complaints and critical incidents including investigation notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for anything other than accommodation, a resident shall be charged only if it was provided under an agreement.

During an interview, a family member of resident #004 indicated to Inspector #655 that funds from resident #004's trust account had been used without his/her knowledge, and not in accordance with a specified pre-existing agreement. The family member of resident #004 indicated to Inspector #655 that the agreement was not followed on two separate occasions. Each time, the family member of resident #004 was not aware that funds were being utilized for a specified reason until a trust account statement was received.

During an interview, DOC #102 indicated to Inspector #655 that for all residents, there is an admission agreement ("Unfunded Services Agreement") made with regards to authorized withdrawals from the resident's trust account. According to DOC #102, Business Manager #101 monitors these agreements.

During the inspection, Inspector #655 reviewed the "Unfunded Services Agreement" for

resident #004. The agreement was made at the time of resident #004's admission to the home. According to the agreement, the home was authorized to withdraw funds from resident #004's trust account for a specified reason only after the resident's family had been consulted.

During an interview, Business Manager #101 reviewed the "Unfunded Services Agreement" and related records with Inspector #655. Business Manager #101 confirmed that there was an agreement in place, as described by the family member of resident #004, related to a specified service. According to Business Manager #101, resident #004's family was to be consulted prior to arranging the specified service because, for a specified reason, when the specified service is utilized for resident #004 there is an additional fee associated with the service at times due to resident #004's specific needs. Business Manager #101 indicated to Inspector #655 that resident #004 had been charged for the specified service, including the additional fee, on three specified occasions within a specified time frame. According to Business Manager #101, the registered nursing staff are responsible for scheduling the specified service and making any related arrangements.

During an interview, RN #100 indicated to Inspector #655 that nursing staff are responsible for scheduling and arranging the specified service and additional arrangements that are associated with additional fees. RN #100 could not recall scheduling the specified service for resident #004 recently; and was unable to speak to whether resident #004's family member would have been consulted prior to making the arrangements for the specified services. RN #100 indicated to Inspector #655 that if resident #004's family had been consulted, it would be documented in the resident's progress notes.

Inspector #655 reviewed resident #004's progress notes as well as other records related to the specified service. In the records reviewed, it was indicated that resident #004 was scheduled for a specified service on three occasions over a period of one month; and that arrangements were made each time that required additional fees. Inspector #655 was unable to locate any documentation that was indicative that resident #004's family member had been consulted prior to arranging the specified service.

Resident #004 was charged for a specified service when it was not provided for under the "Unfunded Services Agreement" without consulting the family member of resident #004 first.

The licensee has failed to ensure that for anything other than accommodation, resident #004 was charged only if it was provided for under an agreement. [s. 91. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under

subsection 23 (2) of the Act, the licensee included all material that is provided for in the regulations in writing.

As per Ontario Regulation 79/10, s. 104 (1), licensees who report investigations under s. 23 (2) of the Long-term Care Homes Act (LTCHA) (2007), shall include all of the material identified in sections 104 (1), 1-5 of the regulation including: a description of the incident including the date and time that the alleged incident occurred, the location of the incident, a description of the individuals involved in the incident including the names of any staff members who were present, whether a physician or Registered Nurse in the Extended Class was notified or authorities contacted, actions taken in response to the incident; and, the analysis and follow-up actions including immediate actions taken and long-term actions planned to correct the situation or prevent recurrence.

In a memo sent from the Director, to all Long-term Care Home Licensees and Long-term Care Home Administrators, it is indicated that licensees must submit the reports required by section 23 of the LTCHA and section 104 of the Regulation through the on-line Critical Incident System (CIS) using the CIS form.

On a specified date, DOC #102 received a written complaint from a family member of resident #004. In the written complaint, the family member of resident #004 alleged that staff had spoken to resident #004 in a specified inappropriate manner.

According to Ontario Regulation 79/10, s. 2:

- "Emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks that are performed by anyone other than a resident; and,
- "Verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

DOC #102 submitted the written complaint, as provided by the family member of resident #004 and described above, to the Director under the Long-term Care Homes Act (2007) on a specified date. DOC #102 also submitted a written response which was addressed to the same family member of resident #004, to the Director. The response letter outlined the outcome of an investigation into the allegation- that was, that the allegation was unsubstantiated, as well as immediate actions taken and long-term actions to be

implemented. There was no information contained in the letter submitted by DOC #102 to the Director under the Long-Term Care Homes Act (2007) related to the date and time of which the alleged incident had occurred, the location of the incident, the names of any staff members involved in the alleged incident, and no indication as to whether a physician or Registered Nurse in the Extended Class had been notified, nor whether any authorities were contacted.

Inspector #655 was unable to locate a Critical Incident System (CIS) report related to the allegation.

During an interview, DOC #102 indicated to Inspector #655 that if a CIS report had been completed with regards to the allegations reported by the family member of resident #004 , it would have been completed and submitted to the Director by ED #103.

During an interview, ED #103 indicated to Inspector #655 that a Critical Incident System report was not completed with regards to the allegations made by resident #004's family member. [s. 104. (1) 1.]

Issued on this 20th day of October, 2017

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

Original report signed by the inspector.