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 prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_560632_0003	003745-17, 013858-17, 018747-17	Critical Incident System

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

BayWoods Place
330 Main Street East HAMILTON ON L8N 3T9

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

YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 5, 7, 8, 11, 2019.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #018747-17, #033297-18 and #033297-18 were related to prevention of abuse and neglect.
Log #013858-17 was related to safe and secure home.

During the course of the inspection, the inspector(s) spoke with the acting Executive Director (acting ED), the former Executive Director (former ED), the Director of Care (DOC), the Assistant Director of Care, (ADOC), Program Manager, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and their families.

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

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	Légende 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. 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 failed to ensure that residents were protected from abuse by anyone and

free from neglect by the licensee or staff in the home.

A CIS report 2581-000006-17 was submitted to the Director in February 2017, alleging abuse of resident #002 by resident #001, which occurred on an identified date in February 2017.

Progress note review indicated that resident #001 was found in co-resident #002's identified location and resident #001 was witnessed demonstrating identified behaviour towards resident #002.

RPN #103 indicated that resident #002 had identified impairment and was not able to provide consent to resident #001's identified behaviour exhibited towards them.

The ADOC acknowledged that resident #002 was not protected from abuse by resident #001.

The home did not ensure that resident #002 was protected from abuse by resident #001.

B. A CIS report 2581-000019-17 was submitted to the Director in August 2017, alleging abuse and/or neglect of resident #003 and resident #004 by PSW #110.

Review of resident #003's and resident #004's plan of care indicated specified interventions for the residents.

Investigation notes were reviewed and indicated that in an identified home area (sometime between April and May 2017), PSW #111 observed that PSW #110 would verbally abuse resident #003 and resident #004 and PSW #110 performed specified actions towards the residents.

In September 2017, PSW #110 was interviewed and indicated that they unintentionally performed specified actions towards resident #003 to get their attention. PSW #110 stated that they did not performed other specified actions towards resident #003 and #004.

The former ED, who was present at the time of the incident investigation, indicated that there was no negative outcome to resident #003 and resident #004 in relation to the incident.

In February 2019, the ADOC acknowledged that resident #003 was not protected from abuse by PSW #110.

The home did not ensure that resident #003 was protected from abuse by PSW #110. [s. 19. (1)]

WN #2: 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 failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Mandatory Reporting of Resident Abuse Policy indicated that anyone who became aware of or suspected abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior Supervisor on shift and they would then together immediately report this to their legislative Authority as per legislation.

A CIS report 2581-000019-17 was submitted to the Director in August 2017, alleging abuse and/or neglect of resident #003 and resident #004 by PSW #110.

Investigation notes review indicated that, on an identified date in August 2017, PSW #111 disclosed to the home's management that in an identified home area (sometime between April and May 2017), PSW #111 observed that PSW #110 would verbally abuse resident #003 and resident #004 and PSW #110 performed specified actions towards the residents. PSW #111 indicated that they told their supervisor about the incident.

PSW #111 was hired by the home in June 2017, and completed their orientation, which

included non-abuse training and mandatory reporting in June 2017.

In February 2019, the acting ED indicated that based on the home's expectations, PSW staff would verbally report to the nurse suspicion of abuse or neglect of a resident. Then the registered staff would assess the resident for injuries related to the incident of alleged abuse and document it in Point Click Care (PCC). The policy directed anyone can report a suspicion of abuse or neglect of a resident, by using after hours phone number and the ED, the DOC and the ADOC submit the on-line report to the Ministry of Health and Long-Term care (MOHLTC) in accordance with Mandatory Reporting of Resident Abuse Policy (effective August 2016).

In February 2019, the ADOC acknowledged that PSW #111 did not report immediately an allegation of abuse of resident #003 and #004 by PSW #110 as per the home's Mandatory Reporting of Resident Abuse Policy, at the time they were a student in the home or once they became a staff member at the home and were educated on the home's expectations on mandatory reporting.

The licensee failed to ensure that the home's Mandatory Reporting of Resident Abuse Policy was complied with when PSW #111 failed to report an allegation of abuse of residents of the home. [s. 20. (1)]

Issued on this 29th day of March, 2019

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

Original report signed by the inspector.