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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 16, 2014	2014_293554_0010	O-000092-14	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

REACHVIEW VILLAGE
130 REACH STREET, UXBRIDGE, ON, L9P-1L3

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

KELLY BURNS (554)

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): March 13, 14 and 28, 2014

Complaint Inspection relating to Log # O-000092-14

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Personal Support Worker (PSW), Activity Program Manager, and family members

During the course of the inspection, the inspector(s) toured the home, reviewed clinical health records relating to discharged resident #001, home's briefing notes relating to the abuse allegation, the home's policies: Resident Non-Abuse, Toolkit for Investigating Abuse and staff education and training records specific to mandatory reporting, prevention of abuse and resident bill of rights.

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

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Resident #001 – Log #O-000092-14

The licensee failed to comply with O.Reg.79/10, s.97 (1)(b) by ensuring that the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Resident #001 was transferred to hospital on a specific date and was admitted to the hospital for treatment.

The Director of Care (DOC) indicated that the home was contacted by the Ministry of Health and Long Term Care on a specified date, indicating that a complaint on behalf of Resident #001 had been initiated; the complaint indicated alleged abuse of the resident.

Director of Care (DOC) indicated that the home did not contact Resident #001's substitute decision maker or other family as to the allegations of abuse within twelve (12) hours of becoming aware of the allegation.

The homes briefing notes, related to the allegation, indicates that the Director of Care, attempted to contact Resident #001's SDM on a specific date; notes indicate the home was unable to reach the SDM or other designated family member on that date, no other attempts are documented.

Resident's Substitute's Decision Maker and another family member, indicated, to Inspector #554, that the home did not contact them as to the allegations of abuse. [s. 97. (1) (b)]

2. Related to Resident #001 – Log #O-000092-14

The licensee failed to comply with O.Reg.79/10, s.97 (2), by ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The home was notified, by the Ministry of Health and Long Term Care (MOHLTC), on a specified date with regards to an abuse allegation, relating to Resident #001. The allegation indicated that a staff member of the home had both physically and verbally abused the resident.

The home’s briefing notes indicated that the investigation was initiated on an identified date, notes further indicate that the investigation was completed 16 days later. DOC indicated the outcome of the investigation was determined to be inconclusive.

The Director of Care indicated that the home did not share the outcome of the investigation with the family.

During an interview, on March 31st, both the Substitute Decision Maker and another family member, indicated that they had not been contacted by the home as to the investigation or the outcome of the same. [s. 97. (2)]

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 by ensuring that a resident's substitute decision maker (SDM) and any other person specified by the resident are notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident; and that the resident and resident's SDM are notified of the results of an alleged abuse or neglect investigation immediately upon the completion, to be implemented voluntarily.

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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. Related to Resident #001 – Log #O-000092-14

The licensee failed to comply with O.Reg. 79/10, s.104(2), by ensuring that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director

Resident #001 was transferred to the hospital and admitted for treatment.

The Director of Care (DOC) indicated that the home was contacted by the Ministry of Health and Long Term Care on a specific date, indicating that a complaint had been lodged on behalf of Resident #001; the complaint alleged that resident was abused while residing at the home. DOC indicated this was the first time she was made aware

of any allegation of staff to resident abuse.

The Home's Briefing Notes related to the abuse allegation, indicate that for the period of 4 days, several attempts were made to contact the hospital to gather details as to the allegation; notes reference unsuccessful attempts as hospital refused to divulge information to the home.

The DOC and the hospital staff agreed to meet on a specified date to interview Resident #001. During the interview, resident communicated that she was scared to get anyone in trouble. Resident communicated to the DOC and others at the meeting that Personal Support Worker #103 was mean and rough with resident during care. Resident #001 during the same meeting indicated 'they were not very nice to me', the resident could not give specifics, but only stated 'the way they did everything'.

The management of the home concluded its investigation; DOC indicated investigation was inconclusive.

During an interview on March 13th, the DOC indicated that to date no Critical Incident Report had been filed by the home pertaining to the allegation of staff to resident abuse.

The Director of Care did not submit the CI until March 17, 2014. [s. 104. (2)]

2. Related to Resident #001 – Log #O-000092-14

The licensee failed to comply with O.Reg.79/10, s.104(3) by ensuring that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The Director of Care indicated that the home was contacted by the MOHLTC on a specific date, regarding an allegation of verbal and physical abuse specific to Resident #001.

The home's investigation was conducted during an identified time period.

The Director of Care indicated in an interview on March 13th, that no preliminary or final report had been submitted with regards to the abuse allegation or as to the

outcome of the investigation, as of the date of this inspection.

Critical Incident had not been submitted to the home at the time of this inspection. [s. 104. (3)]

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 the required report pertaining to allegations of Abuse / Neglect are reported to the Director within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director and or by ensuring that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to Resident #001 - Log #O-000092-14

The licensee failed to comply with O. Reg.79/10, s.98, by ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident.

The Director of Care (DOC) indicated that the home was contacted by the MOHLTC on a specific date, stating that Resident #001 had lodged a complaint to the hospital indicating abuse both physically and verbally, by a staff member of Reachview.

During an interview on March 13th, the DOC indicated the local police force had not been notified by the home of the allegations of abuse made by Resident #001.

DOC acknowledged awareness of the requirements under the Long Term Care Homes Act, but indicated that the assumption was hospital would be responsible for the notification. [s. 98.]

Issued on this 16th day of June, 2014

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