Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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
Jan 7, 2019	2018_773155_0017	002195-18, 002196-18, 002197-18, 009867-18, 011253-18, 013874-18, 018422-18, 025282-18	Follow up

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

Summit Place
850 - 4th Street East OWEN SOUND ON N4K 6A3

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

SHARON PERRY (155), KIM BYBERG (729)

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): December 11, 12, 14, 17, 18, 19, 20, and 21, 2018.

Rhonda Ridgeway #737 was also present for this inspection.

The following intakes were completed in this Follow up inspection:

Log 002195-18 follow up to CO #001, 2017_580568_0026 related to abuse.
Log 002196-18 follow up to CO #002 and Log 002197-18 CO #003, 2017_580568_0026 related to medication incidents.
Log 009867-18, Log 011253-18, Log 013874-18, Log 018422-18, and Log 025282-18 all related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspectors also toured the home; reviewed relevant clinical records, policies and procedures, employee files, meeting minutes, education records, home's investigation records; observed resident and staff interactions, and observed the general cleanliness, safety and condition of the home.

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

During the course of this inspection, Non-Compliances were issued.
 2 WN(s)
 0 VPC(s)
 1 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:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 135. (1)	CO #002	2017_580568_0026	155
O.Reg 79/10 s. 135. (2)	CO #003	2017_580568_0026	155

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 has failed to comply with compliance order #001 from inspection #

2018_773155_0017 served on January 7, 2018, with a compliance date of February 28, 2018.

The licensee was ordered to protect residents from abuse by anyone, and ensure that when there is an altercation between residents that results in abuse, that the residents' behaviours are assessed and interventions identified and implemented in order to minimize the risk of altercations and potentially harmful interactions.

The licensee failed to ensure that residents were protected from abuse by anyone.

On an identified date, the home submitted a Critical Incident System (CIS) report that stated that Personal Support Worker (PSW) #126 was rough with resident #008.

Record reviewed showed that on an identified date, PSW #128 reported to the Executive Director #102 that they witnessed PSW #126 providing care to resident #008 in a rough manner. PSW #126 was interviewed by the Executive Director #102 and shared that they may have been rough while providing care to resident #008.

Record review showed that PSW #126 had completed their annual abuse education.

The licensee failed to protect resident #008 from abuse. [s. 19. (1)]

2. On an identified date, the home submitted a CIS report that stated that PSW #126 verbally abused and was rough while providing care to resident #009.

During an interview with PSW #120 they shared they heard PSW #126 be verbally abusive to resident #009 and immediately reported this to the charge nurse.

The licensee failed to protect resident #009 from abuse. [s. 19. (1)]

3. On an identified date, the home submitted a CIS report that stated PSW #127 was heard by PSW #123 being verbally abusive to resident #014.

Record review showed that PSW #127 had completed their annual abuse education.

During an interview with PSW #123 they shared that PSW #127 was verbally abusive to resident #014.

The licensee failed to protect resident #014 from abuse. [s. 19. (1)]

4. On an identified date, the home submitted a CIS report that stated PSW #116, #118 and Registered Practical Nurse (RPN) #117 placed resident #010 in a non-resident care area.

During an interview with PSW #112 they shared that on an identified date they had placed resident #010 in an area so they were visible to staff. PSW #112 shared that they had gone to provide care to another resident and when returned to the area resident #010 was not visible. PSW #112 shared that they found resident #010 sitting in a non-resident care area.

Review of employee files showed that PSW #116, #118 and RPN #117 had completed their annual abuse education.

The licensee failed to protect resident #010 from abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, the home submitted a Critical Incident System (CIS) report that stated that six days prior resident #010 was found in a non-resident care area.

The Executive Director #102 said that they should have reported the incident to the Director when the incident was reported to them.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARON PERRY (155), KIM BYBERG (729)
Inspection No. / No de l'inspection :	2018_773155_0017
Log No. / No de registre :	002195-18, 002196-18, 002197-18, 009867-18, 011253-18, 013874-18, 018422-18, 025282-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 7, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Summit Place 850 - 4th Street East, OWEN SOUND, ON, N4K-6A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindie Holm

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Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_580568_0026, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically the licensee must ensure that resident #008, #009, #010 #014 and all other residents are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection # 2018_773155_0017 served on January 7, 2018, with a compliance date of February 28, 2018.

The licensee was ordered to protect residents from abuse by anyone, and ensure that when there is an altercation between residents that results in abuse, that the residents' behaviours are assessed and interventions identified and implemented in order to minimize the risk of altercations and potentially harmful interactions.

On an identified date, the home submitted a Critical Incident System (CIS) report that stated that Personal Support Worker (PSW) #126 was rough with resident #008.

Record reviewed showed that on an identified date, PSW #128 reported to the Executive Director #102 that they witnessed PSW #126 providing care to resident #008 in a rough manner. PSW #126 was interviewed by the Executive Director #102 and shared that they may have been rough while providing care to resident #008.

Record review showed that PSW #126 had completed their annual abuse education.

The licensee failed to protect resident #008 from abuse.
(155)

2. On an identified date, the home submitted a CIS report that stated that PSW #126 verbally abused and was rough while providing care to resident #009.

During an interview with PSW #120 they shared they heard PSW #126 be verbally abusive to resident #009 and immediately reported this to the charge nurse.

The licensee failed to protect resident #009 from abuse.
(155)

3. On an identified date, the home submitted a CIS report that stated PSW #127 was heard by PSW #123 being verbally abusive to resident #014.

Record review showed that PSW #127 had completed their annual abuse education.

During an interview with PSW #123 they shared that PSW #127 was verbally abusive to resident #014.

The licensee failed to protect resident #014 from abuse. (155)

4. On an identified date, the home submitted a CIS report that stated PSW #116, #118 and Registered Practical Nurse (RPN) #117 placed resident #010 in a non-resident care area.

During an interview with PSW #112 they shared that on an identified date they had placed resident #010 in an area so they were visible to staff. PSW #112 shared that they had gone to provide care to another resident and when returned to the area resident #010 was not visible. PSW #112 shared that they found resident #010 sitting in a non-resident care area.

Review of employee files showed that PSW #116, #118 and RPN #117 had completed their annual abuse education.

The licensee failed to protect resident #010 from abuse.

The severity of this issue was determined to be a level 2 as there was minimal harm/potential for actual harm to the residents. The scope of the issue was a level three as it related to four of the five residents reviewed. The home had a level 3 history as they had previous related non-compliance with this section of the LTCHA that included:
-CO #001 issued January 7, 2018 (2017_580568_0026).
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of January, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : SHARON PERRY

Service Area Office / Bureau régional de services : Central West Service Area Office