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

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
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2018	2018_610633_0017	021136-16, 012820-17, 021765-17, 023215-17, 024018-17, 004417-18, 004974-18, 008455-18, 014072-18	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

The Village Seniors Community
101-10th Street HANOVER ON N4N 1M9

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

SHERRI COOK (633), MARIA MCGILL (728)

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): August 13-17, 20-23, 2018.

The following intakes were completed during this inspection:

Log #021136-16- related to transferring and positioning.
Log #012820-17, Log #024018-17, Log #004974-18 and Log #008455-18- related to alleged abuse.
Log #021765-17- related to alleged abuse/responsive behaviours.
Log #023215-17- related to alleged neglect and medication administration.
Log #004417-18 and Log #014072-18- related to falls prevention.

Non-compliance identified during this inspection related to LTCHA, 2017, s. 8.(3) has been issued in Follow Up inspection 2018_610633_0016 that was completed concurrently.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Registered Nurses, Registered Practical Nurses, a Physiotherapy Assistant, Personal Support Workers, a Program Aide, a Health Care Aide, a family member and residents.

The inspector(s) also observed residents, resident and staff interactions and care. In addition, the clinical records and plans of care for the identified residents and the home's relevant documentation, that included relevant policies and procedures, were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

- **4 WN(s)**
- **3 VPC(s)**
- **1 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. 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 protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A critical incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an alleged incident of staff to resident abuse. The CI stated that a Personal Support Worker (PSW) witnessed another PSW roughly treating a resident.

The identified PSW denied the incident and said that this incident was a misunderstanding.

A Registered Nurse (RN) said that they considered rough during care to be abuse.

The homes policy titled "Resident Non-Abuse, ADMIN1-P10-ENT", reviewed dated March 31, 2018, had an appendix that defined the types of abuse titled “Types & Definitions of Abuse or Neglect”.

The Executive Director (ED) stated they were unaware of this specific incident however, when asked what they considered to be abuse, the ED stated that being rough during care or any type of contact that was deemed inappropriate or uncomfortable by the resident was considered abuse.

2) Another CI was submitted to the MOHLTC related to the same identified resident being left during care following shift change.

The clinical record documented a progress note that stated that the resident was found left during care for over an hour which had resulted in marks on the residents skin.

The homes investigative records determined that the process for shift change report would be reviewed as there was confusion if staff were notified that the resident was left during care at shift change.

Three staff members all said that they would consider a resident being left on the device to be neglect.

The Executive Director (ED) said that the home's shift reporting processes were reviewed and changed as a result of this incident.

B) A second incident related to the same resident being left on the same device occurred.

A CI was submitted to the MOHLTC that stated that it was reported that the resident had been left during care for up to five hours.

The clinical record for the resident noted that the resident's SDM reported to the registered staff that the resident's had altered skin integrity and this was related to the resident being left on the device. The progress note further stated that two registered staff assessed the resident's skin and noted altered skin integrity and the area now required a specific treatment.

Three staff members all said that they would consider a resident being left during care to be neglect.

The DOC said that the results of the home's investigation confirmed that the resident had been left during care on two separate occasions which had resulted in altered skin integrity. The DOC also said that they would consider this incident to be neglect.

The licensee failed to protect an identified resident from abuse by anyone and failed to ensure that the resident was not neglected by the licensee or staff. [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. 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 :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident, by the licensee or staff, that the licensee knows of, or that was reported was immediately investigated.

A critical incident (CI) report was submitted to the MOHLTC that stated that an identified resident's SDM reported that the resident had been left on a device for up to five hours.

A RPN said that when the issue was brought forward staff had denied that the incident had occurred. A dated progress note dated by the RPN stated that the resident's SDM reported to the registered staff that the resident's had altered skin integrity. The progress note further stated that two registered staff assessed the resident's skin and noted altered skin integrity and the area now required a specific treatment.

The homes investigative records documented a call from resident's SDM stating that the resident may have been left on a device for several hours and they had observed altered skin as a result. The homes investigative records stated that the incident occurred on a specific date and that the investigation was not initiated until four days later following the SDM's telephone conversation with the DOC.

The licensee failed to ensure that an alleged, suspected or witnessed incident of neglect of an identified resident, by the licensee or staff, that the licensee knows of, or that was reported was immediately investigated. [s. 23. (1) (a)]

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, suspected or witnessed incident of neglect of a resident, by the licensee or staff, that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

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 :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred shall immediately reported the suspicion and the information upon which it was 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, 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.

A critical incident (CI) report was submitted to the MOHLTC that stated that an identified resident's SDM reported that the resident had been left during care for up to five hours.

The residents clinical record, the home's investigation records and the DOC stated that this incident occurred on a specific date and the CI was not reported to the MOHLTC until four days later.

B) A critical incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an alleged incident of staff to resident abuse. The CI stated that a Personal Support Worker (PSW) witnessed another PSW roughly treating a resident.

A staff member said that alleged abuse was to be reported immediately. The DOC confirmed that the expectation was that alleged abuse be reported Director immediately and they agreed that this incident was not.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse 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 with the suspicion and the information upon which it was based. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director including: 1) improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, 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, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of an alleged, suspected, or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

A CI was submitted to the MOHLTC that stated an allegation of neglect of an identified resident that had been left during care for several hours.

The clinical record for the resident documented a dated progress note that stated that the resident had been left on a device for upwards of 5 hours and two registered staff assessed the residents skin and determined that their skin integrity was now altered as a result of this incident and the area now required a specific treatment. The progress notes did not include documentation that the residents substitute decision maker (SDM) had been notified of this incident.

The homes investigative records documented a phone call four days later from the resident SDM stating they wanted to follow up with the home as they had heard of the incident and that the resident was now receiving treatment.

The DOC said that it was the expectation that staff notified the SDM for any incident of any sort including abuse/neglect and they agreed that the SDM was not notified immediately. The DOC also acknowledged that they had not talked to the SDM until the SDM had come forward to them.

The licensee failed to ensure that the an identified resident's SDM was immediately notified upon becoming aware of the alleged, suspected, or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident on April 21, 2018. [s. 97. (1) (a)]

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 has the licensee ensured that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected, or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, caused distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

Issued on this 22nd day of October, 2018

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

Original report signed by the inspector.

Ontario

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

Ministére 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

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) :	SHERRI COOK (633), MARIA MCGILL (728)
Inspection No. / No de l'inspection :	2018_610633_0017
Log No. / No de registre :	021136-16, 012820-17, 021765-17, 023215-17, 024018-17, 004417-18, 004974-18, 008455-18, 014072-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 16, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	The Village Seniors Community 101-10th Street, HANOVER, ON, N4N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dylan Subject

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

Order # / Ordre no : 001

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

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 LTCHA 2007, c. 8, s. 19 (1).

Specifically, the licensee must enure that resident #001, and all residents, are protected from abuse by anyone and are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A critical incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an alleged incident of staff to resident abuse. The CI stated that a Personal Support Worker (PSW) witnessed another PSW roughly treating a resident.

The identified PSW denied the incident and said that this incident was a misunderstanding.

A Registered Nurse (RN) said that they considered rough during care to be abuse.

The homes policy titled "Resident Non-Abuse, ADMIN1-P10-ENT", reviewed dated March 31, 2018, had an appendix that defined the types of abuse titled "Types & Definitions of Abuse or Neglect".

The Executive Director (ED) stated they were unaware of this specific incident however, when asked what they considered to be abuse, the ED stated that being rough during care or any type of contact that was deemed inappropriate or uncomfortable by the resident was considered abuse.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of this issue was a level 2 pattern and the home had a level 2 compliance history that included unrelated non-compliance. (728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 16th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Cook

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