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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 30, 2017	2017_463616_0004	034067-16, 034094-16, 035211-16, 035452-16, 004212-17	Critical Incident System

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

JENNIFER KOSS (616)

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 23, 24, 27, 28, March 1, 2, 3, 2017.

The following Critical Incident System (CIS) reports submitted by the home were inspected:

-two reports related to falls with fracture;
-one report related to fall with significant change in condition;
-one report related to allegation of staff to resident abuse;
-one report related to potential staff to resident abuse.

A concurrent Follow Up Inspection #2017_463616_0003 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Acting Director of Care, Assistant Director of Care/Resident Services Coordinator (ADOC), Regional Manager of Clinical Services, Environmental Services Manager (ESM), Resident Assessment Instrument (RAI) Coordinator, Staff Education Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the Inspector directly observed the delivery of care and services to residents, resident to resident and staff to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, and programs.

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

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

1 WN(s)
1 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. 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident System (CIS) report was submitted to the Director in December 2016, related to an incident of alleged staff to resident abuse which occurred one day before the CIS report had been submitted to the Director. The report identified that during an interview on this day with the Registered Dietitian (RD), resident #008 had reported that some staff were very rough with care.

Inspector #616 reviewed the home's investigation record that included an email from the RD to the previous Executive Director and current Director of Care (DOC) on the day the allegation was reported to them. The email provided details of the resident's report including their action of immediately notifying charge Registered Nurse (RN) #101.

The Inspector reviewed the home's policy titled "Resident Non-Abuse", last revised July 31, 2016, that specified 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.

Inspector #616 interviewed the DOC and the Assistant DOC regarding the submission date of the mandatory abuse allegation. The DOC stated that as per the home's policy and staff training, it was the responsibility of RN #101 to have notified the Ministry of Health and Long-Term Care (MOHLTC) when the resident had reported the allegation of abuse.

The Inspector conducted a telephone interview with the RD on March 15, 2017. The RD verified that they had reported the resident's allegation of abuse to RN #101 immediately after conducting their interview with resident #008.

During a telephone interview with the DOC on March 16, 2017, they verified to the Inspector that the most senior supervisor who worked on the day of the resident's allegation of abuse had been RN #101 as the DOC was not in the home. They also confirmed that they had received a telephone call from RN #101 on this day, reporting resident #008's allegation of abuse. The DOC could not recall the time they received the call from the RN however, it was then that they had directed the RN to contact the MOHLTC "after-hours" number to immediately report the allegation of abuse. The next day, the DOC submitted a CIS report to the Director when they became aware that the RN had not done so. [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 or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 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.

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Issued on this 31st day of March, 2017

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

Original report signed by the inspector.