



**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 rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 5, 2016	2016_262523_0020	014813-16	Resident Quality Inspection

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

McGARRELL PLACE
355 McGarrell Drive LONDON ON N6G 0B1

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

ALI NASSER (523), ALICIA MARLATT (590), HELENE DESABRAIS (615), NANCY
SINCLAIR (537)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 17, 18, 19, 20, 24, 25, 26, 31, June 1 & 2, 2016.

**The Following inspections were completed concurrently during the RQI:
Critical Incident Log #002102-16 (CI #2964-000002-16) related to alleged resident to resident abuse.
Critical Incident Log #008839-16 (CI #2964-000008-16) related to alleged staff to resident abuse.
Critical Incident Log #014676-16 (CI #2964-000013-16) related to falls.
Critical Incident Log #022443-15 (CI #2964-000015-15) related to falls.
Critical Incident Log #035412-15 (CI #2964-000026-15) related to alleged staff to resident abuse.
Critical Incident Log #035417-15 (CI #2964-000027-15) related to alleged staff to resident abuse.
Critical Incident Log #015751-16 (CI #2964-000007-16) related to falls.**

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Education Coordinator, two Quality Managers, Registered Dietitian, RAI Coordinator, Food Services Assistant, 11 Personal Support Workers (PSW), nine Registered Staff members, Family Council member, Resident Council member, three family members and over 40 residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:



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**Contenance Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care**

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

4 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights



Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, was fully respected and promoted.

Observations during the inspection revealed that on multiple resident areas a documentation kiosk was found unlocked and unattended with personal health information not kept confidential.

A Licensee report was placed in the information binder at the front door which contained the homes public reports from the MOHLTC.



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 resident right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, was fully respected and promoted, to be implemented voluntarily.

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 :

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A clinical record review revealed that a staff member did not comply with the home's policy titled "Resident Non-Abuse - Ontario", index: LP-C-20-ON and last revised in September 2014, by not reporting their suspicion of abuse of a resident to the management team immediately.



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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:**

- s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,**
- (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).**
 - (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).**

Findings/Faits saillants :

The licensee has failed to ensure that registered dietitian who is a member of the staff of the home completed a nutritional assessment for the resident when there was a significant change in the resident's health condition.

A clinical record review for resident #021 revealed that resident did not receive a nutritional assessment when the staff completed a 'Nutritional Care Referral 2016' due to significant change in the resident's health condition.



WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents

Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A clinical record review revealed that resident #042 had an altercation with other resident that resulted in injuries.

Resident #042 was to be monitored after this incident for a seven day time period.

In an interview RPN #108 and Quality Manager #116 said that they were unable to locate the documentation for the monitoring that was completed for this resident.

Issued on this 7th day of July, 2016

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



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Original report signed by the inspector.