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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 3, 2019	2019_626501_0011	004843-18	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

Eagle Terrace
329 Eagle Street NEWMARKET ON L3Y 1K3

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

SUSAN SEMEREDY (501)

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): May 29, 30, and 31, 2019

The following intake was inspected:
#004843-18 related to the abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), registered nurse (RN), personal support workers (PSW) and residents.

During the course of the inspection, the inspector reviewed health care records, the home's investigation notes, relevant policies and procedures and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
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	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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects their dignity was fully respected and promoted.

The home submitted a Critical Incident System (CIS) report indicating that resident #001 told RN #100, that on an identified date and time, PSW #104 refused to help them, had previously spoken to them harshly and continued to touch them in an identified manner even after being asked not to.

According to resident #001's plan of care, two staff were required to assist with transferring as the resident had decreased strength and balance. For toileting the resident was to be provided an identified assistive aide upon request and for bathing the resident required total assistance from one staff member.

An interview with resident #001 indicated that during their bath on an identified date, PSW #104, touched them on an identified body area which was painful and it was not the first time. According to resident #001, PSW #104 also made a statement related to causing the resident harm. Resident #001 did not recall PSW #104 refusing to assist them but did indicate that PSW #104 was loud and would often speak disrespectfully to them and other residents related to continence care.

An interview with RN #100 indicated resident #001 told them that PSW #104 refused to assist them on an identified date and was always touching them on an identified area of the body even though they had asked the PSW not to. RN #100 stated they checked the resident's identified body area and there was no altered skin integrity.

An interview with PSW #103 indicated that they were the staff member assigned to give resident #001 a bath on an identified date. PSW #103 stated PSW #104 helped transfer resident #001 to the tub and recalled that PSW #104 had touched the resident in an identified area of the body and had made remarks about harming the resident. PSW #103 did not recall resident #001 asking PSW #104 not to touch them, but thought the resident might have complained.

An interview with PSW #104 indicated they admitted to touching resident #001on an identified body area and only once had the resident asked the PSW to stop. PSW #104 stated they did not mean any harm.

A review of the home's investigation notes regarding the above incident indicated video surveillance footage for the evening of the identified date and time, was viewed by the Executive Director (ED) and it was determined that PSW #104 had assisted PSW #103 in the bathroom with resident #001.

The incident that occurred between resident #001 and PSW #104 on an identified date, indicated the PSW failed to treat the resident with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity. [s. 3. (1) 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 every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects their dignity is fully respected and promoted, to be implemented voluntarily.

Issued on this 12th day of June, 2019

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

Original report signed by the inspector.