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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2015	2015_328571_0014	028988-15	Complaint

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

FOSTERBROOKE
330 KING STREET WEST NEWCASTLE ON L1B 1G9

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 26 and 27, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Food Service Manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aide, Resident and the Resident's Power of Attorney.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 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 has failed to ensure that when resident #001's Power of Attorney (POA) reported suspected abuse to the home that it was immediately investigated.

Re: Log #028988-15:

A complaint was received by the Director on a specified date. The POA of resident #001 reported bruising on the resident that looked "as if someone had grabbed" resident #001.

In an interview, RN #102 indicated that on a specified date, that resident #001 had a "bruise that looked like finger marks". The POA of resident #001 reported it to RN #102. RN #102 assessed the bruise, documented it in the progress notes, and entered the bruise in the electronic treatment book for daily monitoring. RN #102 indicated the incident was reported to the Director of Care (DOC).

On November 26, 2015, the Executive Director (ED) and the DOC indicated in an interview, that they had discussed resident #001's bruises in a meeting but were not aware that they had to investigate the bruising as suspected abuse.

Therefore, the licensee failed to investigate an incident of suspected abuse immediately. [s. 23. (1) (a)]

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 has failed to ensure that suspected abuse of resident #001, was reported immediately to the Director.

Re: Log #028988-15:

A complaint was received by the Director on a specified date. The POA of resident #001 reported bruising on the resident that looked "as if someone had grabbed" resident #001.

In an interview, RN #102 indicated that on a specified date, that resident #001 had a "bruise that looked like finger marks". The POA of resident #001 reported it to RN #102. RN #102 assessed the bruise, documented it in the progress notes, and entered the bruise in the electronic treatment book for daily monitoring. RN #102 indicated the incident was reported to the Director of Care (DOC).

The Executive Director (ED) indicated in an interview on November 26, 2015, that resident #001's bruise was not reported to the Director. The ED did make a report to the Director on November 26, 2015 at 1644 hours.

Therefore, the licensee failed to report an incident of suspected abuse immediately to the Director. [s. 24. (1)]

Issued on this 21st day of December, 2015

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

Original report signed by the inspector.