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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Nov 18, 2013;	2013_225126_0022 (A1)	O-000587,000643,000718-13	Critical Incident

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

MONTFORT
705 Montreal Road, OTTAWA, ON, K1K-0M9

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please note that an extension of 1 week from October 31, 2013 to November 7, 2013 was granted to ensure education was completed with all staff.

Issued on this 18 day of November 2013 (A1)

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

Ontario

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MONTFORT
705 Montreal Road, OTTAWA, ON, K1K-0M9

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 18, 19, 20 and 25, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Assistant Director of Care, several Registered Nurses, several Registered Practical Nurses and several Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed several Resident health care records, viewed the home video for one incident, reviewed the home policy on medication administration Policy LTC-F-20.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 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 comply with LTCHA, S. O. 2007, c. 8, s. 19. (1) in that the licensee did not protect Resident #3 and Resident #7 from physical abuse by Resident #2 . O. Reg 79/10 s.2(2)(c)define physical abuse as the use of physical force by a resident that causes physical injury to another resident.

1)Resident #2 exhibited aggressive behaviours on several occasions for a period of 6 days prior to the incident of physical abuse toward Resident #3:

On a specified day in 2013, Resident #2 tried to break down the door to get off the unit. It was documented in the progress notes, that Resident #2 behaviours were difficult to manage. The resident was yelling and wanted to hit staff. The physician, the police and the family were notified of the resident behaviours.

The next day, Resident #2 sat at a table that he/she was not assigned to. Staff requested that the resident to his/her assigned table and Resident #2 refused categorically and became angry. The staff left the resident sit where he/she wanted.

Four days after the above incident , it is documented in the progress notes that at breakfast time, Resident #2 became upset at the Dietary Aid(DA) staff because he/she wanted to have a banana immediately. When the DA turned to give the banana, Resident # 2 held the DA at the back of his/her neck to hit him/her. The Registered Nurse (RN) tried to intervene, Resident #2 tried to kick the RN and was following him/her to hit him/her with his/her fists. The RN ran to the computer room and waited a few minutes until Resident #2 moved away form the door. At lunch time, Resident #2 did not remember the incident.

The following day of that incident on a specified day in July 2013, Resident #2 was in the hall way and hit Resident #3 until they were separated by staff. Resident # 3 sustained an injury.

Resident #2 exhibited several incidents of aggressive behaviours prior to hitting Resident #3. Effective interventions were not put in place to ensure protection of residents.

2)The licensee did not ensure that 2 residents with responsive behaviours were closely monitored . On a specified day in August 2013, Resident #2 pushed Resident #7 to the floor and Resident #7 sustained a laceration to the back of her/his head.

Resident #2 was known to have aggressive behaviour in the past and was recently discharge from hospital. Since his discharge from hospital Resident #2 had not exhibited any aggressive behaviours until that day.

Prior to the incident of that specified day in August 2013, Resident #7 was known to have increased agitation and aggressive behaviours for several days.

The home video of that specified day in August 2013, monitoring residents in the dining room was viewed by Inspector #126. It was observed that Resident #2 was sitting quietly in the dinning room. Resident #7 approached the table of where Resident #2 was sitting. Resident # 2 was observed to be pointing his/her finger at Resident #7. Resident #7 was observed to take his/her slipper and banged it on the table. Resident #2 stood up and pushed Resident #7 to the floor. After the fall, 2 Personal Support Worker (PSW)s were informed of the fall by a visitor . On the video, both PSWs came to the scene, one PSW tried to approached Resident #7 and Resident #7 made signs with his/her hands indicating to the PSW to go away. Then both PSWs went back to were they came from without informing the Nurse. The visitor kept looking for assistance for several minutes. The PSW went to informed the nurse approximately 10minutes after she was originally told about the incident. The Registered Nursing staff arrived and assessed Resident #7.

The home did not monitor closely two residents with potential and actual behaviours to ensure residents were safe and protected from potential abuse. The two PSWs that were informed of the incident did not take immediate action to notify the Nurse and did not ensure of the whereabouts of Resident #2. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s.8. (1)in that the home did not the home policy on Medication Administration LTC-F-20 in not being able to administered the medication ordered by the physician and by the pharmacy and the home not transcribing an order as per the physician order.

Policy Medication Administration LTC-F-20 requires staff to:
10. Medication will be administered following the "rights" of medication administration
14. The pharmacy provider will be notified immediately if medication ordered is not available for administration. The Physician/ Nurse Practitioner will be notified if medication is not available.

On a specified day in July 2013, Resident #2 exhibited aggressive behavior, the physician was contacted and ordered a sedative Intra Muscular (IM) to be given immediately. Registered Staff #100, documented in the progress notes of that day, that the IM medication was not available therefore the medication was given by mouth Resident #2 became calm after 30 minutes.

On September 19, 2013, Inspector #126 reviewed Resident #2 health care record. It was documented in the physician order on a specified day in August 2013 , a specified sedative to be given by mouth or IM if needed. The Medication Administration Record (MAR) was reviewed and it was noted that the transcription of the sedative order did not include the IM route as per physician order

On September 19, 2013, Inspector#126 inspected the Emergency dug box and the sedative injectable was not available. Registered Practical Nursing staff # 101 indicated that if it is not on the list "Trousse des medicaments d'urgence 2013" then it was not available.

Issued on this 18 day of November 2013 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDA HARKINS (126) - (A1)

Inspection No. / No de l'inspection : 2013_225126_0022 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-000587,000643,000718-13 (A1)

Type of Inspection / Genre d'inspection: Critical Incident

Report Date(s) / Date(s) du Rapport : Nov 18, 2013;(A1)

Licensee / Titulaire de permis :
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

LTC Home / Foyer de SLD :
MONTFORT
705 Montreal Road, OTTAWA, ON, K1K-0M9

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : GAETAN GRONDIN

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 shall prepare, submit and implement a plan for achieving compliance to ensure action is taken to protect all residents from Resident #1 aggressive behaviours by:
-monitoring the whereabouts of Resident #2 at all times to protect the other residents;
- Identify potential residents that are vulnerable to abuse by Resident #1 and conduct risk analysis to take steps to protect those residents at all times;
-intervene immediately if Resident #1 demonstrate verbal and physical abuse;
-implementing and discussing recommendations with the psycho geriatric team
-educating personal support worker on the management of aggressive behaviours
-developing an effective intervention plan to protect the other resident and if plan of care is not effective take appropriate action to protect
-Review and revise the plan of care of Resident #1 to ensure clear direction is
provided to staff and others related to the management of the aggressive behaviours
- Ensure alleged, suspected or witnessed incident of abuse are thoroughly investigated and appropriate action is taken in response to every such incident

This plan must be submitted in writing to Inspector Linda Harkins at 347 Preston Street, 4th floor, Ottawa ON K1S 3J4 or by fax at 613-569-9670 on or before October 7, 2013.

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA, S. O. 2007, c. 8, s. 19. (1) in that the licensee did not protect Resident #3 and Resident #7 from physical abuse by Resident #2 . O. Reg 79/10 s.2(2)(c)define physical abuse as the use of physical force by a resident that causes physical injury to another resident.

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The home did not monitor closely two residents with potential and actual behaviours to ensure residents were safe and protected from potential abuse. The two PSWs that were informed of the incident did not take immediate action to notify the Nurse and did not ensure of the whereabouts of Resident #2. [s. 19. (1)] (126)

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

Nov 07, 2013(A1)

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18 day of November 2013 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

Service Area Office /
Bureau régional de services : Ottawa