Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 28, 29, Mar 1, 7, 8, 9, Apr 10, 2012	2012_026147_0007	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

NORTHRIDGE
496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), staff and residents.

During the course of the inspection, the inspector(s) Interviewed the Administrator, Assistant Director of Care and Staff, reviewed clinical charts and progress notes, reviewed Policy and Procedure related to Skin and Wound, Continence Program, Responsive Behaviour and abuse and neglect, internal investigation and Internal incident report reviewed.

H-002446-11
H-002533-11
H-001877-11

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

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Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

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 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 :

1. The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including, 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. [r.54 (a)]

An identified resident was involved in an altercation in 2012 where staff observed the resident hitting another resident. According to the resident's Resident Assessment Protocols (RAPs) for the past three quarters, the resident shows aggression towards staff and is at risk for harming others residents. However, the home failed to minimize the potential of harmful altercations by not identifying factors, based on an interdisciplinary assessment that could potentially trigger such altercations for the resident.

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Issued on this 4th day of May, 2012

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