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
Jan 29, 2019	2019_565647_0002	002431-18, 003778-18, 006364-18, 006635-18, 017928-18, 029722-18, 030245-18, 031868-18, 000328-19	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

Oak Terrace
291 Mississaga Street West ORILLIA ON L3V 3B9

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

JENNIFER BROWN (647), JADY NUGENT (734), SHANNON RUSSELL (692)

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): January 22 - 25, 2019.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
-two related to resident to resident abuse,
-three related to declared outbreaks,
-four related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Staff Educator, Housekeepers, Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations in resident home areas, and care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours

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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A Critical Incident System (CIS) report was received by the Director in response to a physical altercation between resident #005 and resident #008.

Inspector #734 conducted a review of resident #005's health care records which indicated that they had exhibited responsive behaviours since their admission. The progress notes indicated the home implemented a specific intervention which included documenting the intervention upon admission to monitor for any exhibited responsive behaviours by resident #005 at an identified frequency.

A review of the specific intervention for resident #005 from an identified period of time, indicated that documentation had been missing on 10 days at specific times.

In an interview with direct care staff member #116, they verified that staff initiate the identified specific intervention when a resident was at risk of exhibiting responsive behaviours. During an interview with Registered staff member #107, they also indicated that when a resident was exhibiting high risk behaviours that the specified intervention

would be implemented. This Registered staff member confirmed that blank spaces within the documentation indicated that the specific intervention was not completed by staff.

During an interview with the home's Staff Educator #118, they confirmed that the expectation was for staff to implement and document the specific intervention for resident #005. Together, Inspector#734 and Staff Educator #118 reviewed resident #005's documentation record from the identified period of time indicated above, and identified multiple areas of missing documentation. The Staff Educator #118 confirmed that the missing documentation indicated that staff did not document the information for resident #005. [s. 55. (a)]

2. A CIS report was received by the Director in response to a physical altercation between resident #006 and resident #007.

Inspector #734 conducted a review of resident #006's health care records which indicated that they had exhibited responsive behaviours since their admission. The progress notes indicated the home implemented a specific intervention which included documenting the intervention upon admission to monitor for any exhibited responsive behaviours by resident #006 at an identified frequency.

A review of the specific intervention for resident #006 from an identified period of time, indicated that documentation had been missing on five days at specific times.

In an interview with Registered staff member #106, they verified that staff initiate the identified specific intervention when a resident was at risk of exhibiting responsive behaviours. During an interview with Registered staff member #112, they also indicated that when a resident was exhibiting high risk behaviours that the specified intervention would be implemented. In another interview with Registered staff member #107, they confirmed that blank spaces within the documentation indicated that the specific intervention was not completed by staff.

During an interview with the home's Staff Educator #118, they confirmed that the expectation was for staff to implement and document the specific intervention for resident #006. Together, Inspector#734 and Staff Educator #118 reviewed resident #006's documentation record from the identified period of time indicated above, and identified there were multiple missing documentation. The Staff Educator #118 confirmed that the missing documentation indicated that staff did not record the information for resident #006. [s. 55. (a)]

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 procedures and interventions are implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.