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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2013	2013_201167_0024	H-000289-13	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

RIDGEVIEW
385 HIGHLAND ROAD WEST, STONEY CREEK, ON, L8J-3X9

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 6, 10 & 11, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, registered staff and personal support worker staff and the identified residents.

During the course of the inspection, the inspector(s) conducted a review of the health files for the identified residents, reviewed relevant policies and procedures at the home, reviewed staff training records and observed care and interactions between residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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.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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident # 006 was protected from abuse by a co-resident.
A) On an identified date in 2013 Resident # 006 was found on the floor in the hallway in front of their room with two co-residents standing in front of them.
- Resident # 006 indicated to staff that one of the co-residents pushed them causing them to fall.
- Another co-resident who reportedly witnessed the incident confirmed that the accused co-resident pushed resident # 006.
-Resident # 006 sustained an injury but did not require transfer to hospital.
Resident # 006 was not protected from abuse by a co-resident. [s. 3. (1) 2.]

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 the right of all residents to be protected from abuse is respected., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records

Every licensee of a long-term care home shall ensure that,

(a) a written record is created and maintained for each resident of the home; and

(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that the written record for resident # 006 was maintained and kept up to date at all times.

A) Resident # 006 sustained a witnessed fall on an identified date in 2013 resulting in a minor injury.
- The progress note stated that the resident had an injury and the progress notes indicated that the resident had apparently had an altercation with a co-resident.
- Four days later, the registered staff reported in the progress notes that the resident had sustained a different injury related to another incident with a co-resident.
- There was no documentation to indicate when this alleged altercation occurred, where it occurred, the circumstances surrounding the incident or any actions taken as a result of the incident.
- The documentation on the resident's health file was not maintained to include an account of this alleged incident.

B) Resident # 006 sustained a fall and a mobile X-ray was ordered and was scheduled to be completed three days later.
- The X-ray was not completed until five days later.
- During an interview with the Director of Care and two registered staff, it was confirmed that the day prior to scheduled date for the X-ray to be completed, the resident's family member visited the home and indicated that they felt that the X-ray was not required. The X-ray was consequently cancelled.
- Two days later another family member visited and requested that the X-ray be re-ordered.
- The X-ray was re-ordered and completed one day later.
- Although confirmed by the two registered staff, this information was never documented in the resident's health file. [s. 231.]

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 a written record is created and maintained for each resident and that the resident's written record is kept up to date at all times., to be implemented voluntarily.

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Issued on this 2nd day of October, 2013

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