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

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_0023	H-000585-13	Follow up

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 4, 5, 6,10, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Administrator, registered staff and personal support worker staff, identified residents and the Resident Assessment Instrument Coordinators (RAI Coordinator).

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

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a 24-hour admission care plan was developed for residents # 001 and # 002 that included identification of any risk that the resident may pose to others, including potential behavioural triggers, and safety measure to mitigate those risks.

A) When Resident # 001 was admitted to the home, the document that is titled "Admission Assessment and Plan of Care" found in the resident's health care record and confirmed by registered staff and the DOC as being the document that is used as a 24 hour care plan for residents did not include all required information related to the behaviours displayed by the resident or interventions in place to manage these behaviours.
- The information that was provided to the home on the Minimum Data Set Home Care (MDS-HC) report and the Community Care Access Centre (CCAC) MDS application form indicated that the resident had displayed a number of behaviours prior to their admission to the home.
- During a review of the progress notes completed during the first week after the resident's admission to the home, it was noted that the documentation completed by staff confirmed that the resident was continuing to display the identified behaviours.

The 24 hour care plan completed by the home did not include any of these behaviours or interventions to manage the behaviours.

B) When Resident # 002 was admitted to the home, the document that is titled "Admission Assessment and Plan of Care" found in the resident's health care record and confirmed by registered staff and the DOC as being the document that is used as a 24 hour care plan at the home did not include all required information related to the behaviours displayed by the resident or interventions in place to manage these behaviours.
- The information that was provided to the home on the Community Care Access Centre (CCAC) Behavioural Assessment Form, indicated that the resident had displayed a number of behaviours prior to their admission to the home.
- During a review of the progress notes completed during the first week after the resident's admission to the home, it was noted that the documentation completed by staff confirmed that the resident continued to display a number of the identified behaviours.
The 24 hour care plan completed by the home did not include any of these behaviours nor were there interventions in place to monitor and manage the behaviours. [s. 24.

1. The licensee did not ensure that a 24-hour admission care plan was developed for r

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 24-hour admission care plan is developed for each resident that includes identification of any risks that the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care for resident # 002 was provided to the resident as specified in the plan.

A) During a review of the document that the home refers to as the care plan for resident # 002, it was noted that the resident requires the use of one half rail when they are in bed.
B) During an interview with a registered staff member, they confirmed that the resident uses one half rail when in bed.
C) During observations of resident # 002 on three occasions during the inspection, it was noted that the resident was in bed and both half rails were raised.
Staff at the home did not provide care as set out in the plan of care for resident # 002 related to the use of bed rails. [s. 6. (7)]

2. The licensee did not ensure that the staff and others who provide direct care to the resident have convenient and immediate access to their plan of care.

A) Resident # 002 sustained a fall on an identified date in 2013. The document that the home refers to as the care plan for resident # 002 found in the home's computerized documentation system was updated after this fall to include changes in the resident's level of mobility, indicating that the resident now required two person assist for transfers and use of a wheelchair with a chair alarm.
-During interviews with registered staff and personal support worker staff, it was confirmed that staff were aware that that they were to use two persons for transfers and that the resident was using a wheelchair with a chair alarm.
- The care plan that was found in the care plan binder and was accessible to direct care staff did not reflect these changes in mobility.

Staff and others who provide direct care to the resident did not have immediate and convenient access to the resident's most current plan of care. [s. 6. (8)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

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COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 26. (3)	CO #002	2012_205129_0004	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2012_205129_0004	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #003	2012_205129_0004	167

Issued on this 2nd day of October, 2013

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

Marilyn Tone