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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2015	2015_226192_0018	001518-15	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

DEBORA SAVILLE (192)

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): April 14 and 15, 2015

**This Complaint inspection related to IL-36862-LO was completed concurrently with:
Critical Incident log number 003244-15 CI2915-000005-15
Complaint log number 003856-15 IL-0037433-LO and IL-37676-LO.**

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Nursing, Assistant Director of Nursing Care, registered nurses, registered practical nurses, personal support workers, Resident Assessment Instrument (RAI) Coordinators, and a Neighbourhood Coordinator.

In completing this inspection the inspector reviewed; medical records, incident reports, policy and procedure.

**The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services**

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 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	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. 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled Weight & Height Monitoring dated January 2013 stated that all residents will be weighed and height measured upon admission.

Resident #001 was admitted to the home in 2014. Record review and interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that no weight or height was documented for resident #001.

Documentation by the Registered Dietitian confirmed that no height and weight were available during their assessment of resident #001.

The licensee failed to ensure that the Weight and Height Monitoring Policy was complied with. [s. 8. (1) (b)]

2. The home's policy titled Admission of Resident dated January 2013 stated that an Admission Physical will be completed by the Physician within seven days and the Admission Checklist stated that a skin assessment will be completed at admission.

Resident #001 was admitted to the home in 2014. Record review identified that no Admission Physical had been completed for resident #001 at the time of discharge, 10 days following admission.

Record review and interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that no skin assessment was completed for resident #001 at the time of admission.

The licensee failed to ensure that the "Admission of Resident" policy was complied with. [s. 8. (1) (b)]

3. The home's policy titled Fall Prevention and Management (LTC) dated February 2013 indicated that post fall; in all cases, the family or Power of Attorney (POA) is to be notified of the fall.

Resident #001 was found on the floor on a specified date. Interview with family

confirmed that they received no notification that the resident had sustained a fall. Record review identified that it had been documented that the family would be notified the following day. Record review and interview confirmed that their was no indication that the family had been notified of resident #001's fall.

Interview with the Assistant Director of Care confirmed that a fall occurring through the day or early evening should result in the family being notified of the fall on the day of the fall.

The licensee failed to comply with the Fall Prevention and Management Policy when family were not notified of a fall sustained by resident #001. [s. 8. (1) (b)]

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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act.

Resident #001 was admitted to the home in 2014.

Information provided by the placement co-ordinator indicated that resident #001 required extensive assistance with activities of daily living and was incontinent of bladder. The resident was identified to be at high risk of falls.

A discharge summary completed prior to admission and provided by the placement co-ordinator indicated that the resident had previously been admitted to hospital related to falls.

A Behaviour Assessment Tool completed prior to admission and provided by the placement co-ordinator indicated that the resident exhibited specified responsive behaviours and was at high risk for falls.

Record review and interview with a Resident Assessment Instrument (RAI) Coordinator confirmed that the care plan in effect at admission, stated that the resident required limited assistance with activities of daily living and was occasionally incontinent. The care plan did not include the residents risk of falls, or identified behaviours.

Resident #001 sustained a fall without injury and frequently refused care, meals and fluid intake from the time of admission. [s. 24. (4)]

2. Resident #003 was admitted to the home in 2015.

The assessments, reassessments and information provided by the placement co-ordinator identified that the resident exhibited identified responsive behaviours.

Record review and interview with the Director of Care and a Resident Assessment Instrument (RAI) Coordinator confirmed that the admission care plan completed at admission did not identify any behaviours the resident may express. The Director of Care indicated that a "Resident Move-in Information Form" had been completed for

resident #003 and would be available, in the medical record or in the communication binder, to staff providing care. This document would identify expressions presented by resident #003.

Observation and interview with the RAI Coordinator confirmed that the "Resident Move-in Information Form" completed for resident #003 had not been made available to staff providing care.

The licensee failed to ensure that the care set out in the 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator. [s. 24. (4)]

3. The licensee failed to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change.

Resident #003 was admitted to the home in 2015. A care plan was created that identified the resident to be at risk of falls.

Record review identified that on the day of admission resident #003 sustained a fall. A monitoring device was put into place.

Record review and interview with a Resident Assessment Instrument (RAI) Coordinator confirmed that the care plan had not been updated to include the residents behaviour that increased their risk for falls or the use of the monitoring device.

The licensee failed to ensure that the care plan for resident #003 was reviewed and revised when the resident's care needs change. [s. 24. (9) (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 ensuring that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act, to be implemented voluntarily.

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.