



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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
Direction de l'amélioration de la
performance et de la conformité**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 13, 2016	2015_253614_0018	019330-15	Complaint

Licensee/Titulaire de permis

Schlegel Villages 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

CAROLYN MCLEOD (614)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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

This inspection was conducted on the following date(s): December 16, 17, 2015.

The Inspector also observed care being provided on the neighborhoods, reviewed clinical records, related home policies and procedures and the investigation notes pertaining to CIS# 2915-000026-15

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Care, Assistant Director of Care, one Registered Practical Nurse, three Personal Support Workers

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

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

3 WN(s)

3 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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. 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 was complied with.

An incident occurred on a specific date involving two residents.

The home's policy Prevention of Abuse in Long-Term Care, revised July 2015, stated that both residents were to have had a head to toe assessment completed.

A review of the clinical records for the residents failed to reveal a head to toe assessment for either resident.

A telephone interview with the Assistant General Manager confirmed that a head to toe assessment was both the policy and the expectation of the home, and that it was not completed on either resident.

The home failed to ensure that the prevention of abuse policy was complied with. [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 to ensure that any plan, policy, protocol, procedure, strategy or system, the licensee is required, to ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours



Specifically failed to comply with the following:

- s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
- (a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
 - (b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
 - (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers for the resident were identified and that strategies for dealing with responsive behaviours were developed and implemented.

Two residents were involved in an un-witnessed incident on a specific date.

A review of the care plan for one of those residents revealed that there were no behavioural triggers nor any strategies related to the resident's behaviours identified in the care plan for that resident at the time of the un-witnessed incident.

An interview with of the Behavioural Support Ontario (BSO) team in the home, confirmed that they were aware that the identified resident had exhibited behaviours previously, and what the identified resident's triggers were.

The licensee failed to ensure that behaviour triggers were identified and strategies developed and implemented when the identified resident exhibited behaviours. [s. 53. (4)]



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée

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 identifying behavioral triggers and subsequently developing strategies for residents to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified and strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: 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 licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including, implementing interventions.

According to a Critical Incident (CI) report, following an incident involving two residents, one of the residents was placed on one to one monitoring.

An update to the same CI report, on a specific date, indicated that the resident was not monitored by a staff member on a one to one basis for a period of time and the resident was involved in an incident with another resident.

An interview with the Director of Resident Care confirmed that the staff member providing the one to one monitoring was performing other duties and did not keep the resident in her sight at all times, as was the expectation of the home.

The licensee failed to ensure steps were taken to minimize the risk of potentially harmful interactions between residents. [s. 54. (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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions, to be implemented voluntarily.

Issued on this 19th day of January, 2016

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Original report signed by the inspector.