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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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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
Aug 26, 2016	2016_325568_0017	021576-16 / 012874-16	Critical Incident System

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

DOROTHY GINTHER (568)

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): August 16, 17, 18, 2016

Critical Incident 2915-000022-16 and 2915-000050-16 were related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Nursing, one Registered Nurse, one Nursing Consultant, one Neighbourhood Coordinator, three Registered Practical Nurses, one Personal Expressions Resource Team member, and eight Personal Care Aides.

The Inspector also observed the provision of resident care, resident-resident and staff-resident interactions; reviewed relevant clinical records, investigation notes and related policies and procedures.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 :

The licensee has failed to ensure that procedures and interventions were 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 that minimize the risk of altercations and potentially harmful interactions between and among residents.

A Critical Incident (CI) report was submitted to the Director which described an incident where an identified resident demonstrated responsive behaviours toward staff when they tried to provide care. Team members did not challenge the resident but gave them space. The resident's behaviours appeared to settle, but within a short time the behaviours escalated and put residents at risk of harm. The CI noted that the identified resident had a history of responsive behaviours for which they had been assessed for in the past. Actions taken in response to this incident included increased resident support, review of the incident to identify any triggers, as well as strategies to manage and/or prevent the identified behaviours.

A Critical Incident report submitted approximately seven weeks following the first report described another incident where the same resident exhibited responsive behaviours which posed a risk of harm to staff and other residents. The physician was called and the decision was made with nursing team support to transfer the resident for further assessment/evaluation.

On a specified date Inspector #568 observed an incident where staff and other residents were at risk of harm as a result of the identified resident's responsive behaviours. The RPN in charge alerted care staff in the common areas of the home that the resident was demonstrating responsive behaviours. Staff were not observed to implement strategies to minimize the potential risk of harm to staff and/or residents.

During an interview with a RPN, they shared that although they were aware of previous incidents involving the identified resident, they had never witnessed the resident's responsive behaviours. The RPN indicated that the plan of care and verbal communication at shift report allowed staff to be informed of possible triggers for the resident's behaviours and suggested management strategies. When asked if procedures and interventions had been put in place should the initial response not be effective, the RPN stated that they would call the charge nurse and otherwise focus on ensuring the

safety of the resident and other residents in the home.

A PCA told inspector #568 that they were providing care for the identified resident on the day of the incident. The PCA indicated that they were familiar with the resident, the types of behaviours they exhibited and some of the strategies used to help manage them. The PCA stated that they had never actually witnessed the identified resident's responsive behaviours. Following the most recent incident where the resident exhibited escalating responsive behaviours toward staff and residents, the PCA stated that they had never seen the resident like that and were concerned for the safety of others.

Review of the resident's plan of care related to Mood State/Personal Expressions identified the resident as having unpredictable responsive behaviours. A number of interventions were documented to address these behaviours. Review of progress notes for the identified resident during a three and a half month period identified ten incidents of responsive behaviours that posed a risk to staff and/or residents.

A RPN told Inspector #568 that until very recently they worked on the neighbourhood where the identified resident resided. When asked if the staff member was aware of a specific procedure to follow when the identified resident exhibited the responsive behaviours, they said they were aware of the strategies, but when the behaviour comes on with no warning it was more difficult and you just tried to focus on protecting yourself and the other residents.

During interviews with four PCAs and one RPN they told this inspector that they were aware of the nature of the identified resident's responsive behaviours but when asked what procedures and interventions were in place to assist the staff and residents that were at risk of harm, the staff were unsure. They indicated that if there was an incident they would call for assistance using the call bell or go to get the team lead. Otherwise, they would just try to keep the resident involved and other residents safe.

The NC and Personal Expression Resource Team (PERT) PCA told this inspector that staff receive education on the unit, participate in huddles and discussions at shift report related to managing residents with responsive behaviours. Both staff agreed that the focus with the identified resident had been on preventing the behaviours and less on procedures to respond to the heightened behaviour in order to minimize potentially harmful situations. The NC and PERT PCA acknowledged that more education was needed to ensure that there were procedures and interventions in place to assist the residents and staff who were at risk of harm or were harmed because of a resident's

behaviours, to minimize the risk of potentially harmful interactions.

During an interview with the Director of Nursing (DON) and Assistant General Manager (AGM) they indicated that the identified resident had been followed closely related to their responsive behaviours. The resident was discussed regularly at their risk management meetings, was being followed by the home's Personal Expressions Resource Team and had several assessments completed related to their behaviours. A number of strategies had been developed to prevent / manage these behaviours and a great deal of staff education had been provided with respect to identifying triggers for the resident, being aware of early signs and management strategies to minimize risk of altercations or harm to residents. Despite the education, the AGM and DON acknowledged that the response to the identified resident's physically aggressive behaviours on at least two occasions put other residents and staff in a potentially harmful situation. The AGM and DON agreed that specific procedures and interventions had not been developed and implemented for staff and residents at risk of harm, to minimize altercations and potentially harmful situations.

The scope of this issue was a pattern and the severity of harm a level two with potential for actual harm to residents. The home had a history of non-compliance in a similar area. During an inspection December 30, 2014 a Voluntary Plan of Correction was issued with respect to s. 53 (4) pertaining to the identification of behavioural triggers, development and implementation of strategies for the behaviours. A Voluntary Plan of Correction was issued again relating to s. 53. (4) and for s. 54 (b) ensuring that steps were taken to minimize the risk of altercations between residents. A Compliance Order was issued with respect to s. 54. (b) on April 18, 2016 with a compliance date of May 20, 2016. The order was complied during the follow-up inspection commencing July 12, 2016. [s. 55. (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 22nd day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568)
Inspection No. / No de l'inspection :	2016_325568_0017
Log No. / Registre no:	021576-16 / 012874-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 26, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. 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.

Order / Ordre :

The licensee shall ensure that procedures and interventions are developed and implemented for residents and staff who are at risk of harm or who have been harmed by resident #001, and any other resident exhibiting responsive behaviours, to minimize the risk of altercations and potentially harmful interactions between and among residents. The home will ensure that all staff providing care for resident #001 and any other resident with responsive behaviours, are made aware of these procedures and interventions and have sufficient training to implement them.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were 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 that minimize the risk of altercations and potentially harmful interactions between and among residents.

A Critical Incident (CI) report was submitted to the Director which described an incident where an identified resident demonstrated responsive behaviours toward staff when they tried to provide care. Team members did not challenge the resident but gave them space. The resident's behaviours appeared to settle,

but within a short time the behaviours escalated and put residents at risk of harm. The CI noted that the identified resident had a history of responsive behaviours for which they had been assessed for in the past. Actions taken in response to this incident included increased resident support, review of the incident to identify any triggers, as well as strategies to manage and/or prevent the identified behaviours.

A Critical Incident report submitted approximately seven weeks following the first report described another incident where the same resident exhibited responsive behaviours which posed a risk of harm to staff and other residents. The physician was called and the decision was made with nursing team support to transfer the resident for further assessment/evaluation.

On a specified date Inspector #568 observed an incident where staff and other residents were at risk of harm as a result of the identified resident's responsive behaviours. The Registered Practical Nurse (RPN) in charge alerted care staff in the common areas of the home that the resident was demonstrating responsive behaviours. Staff were not observed to implement strategies to minimize the potential risk of harm to staff and/or residents.

During an interview with a RPN, they shared that although they were aware of previous incidents involving the identified resident, they had never witnessed the resident's responsive behaviours. The RPN indicated that the plan of care and verbal communication at shift report allowed staff to be informed of possible triggers for the resident's behaviours and suggested management strategies. When asked if procedures and interventions had been put in place should the initial response not be effective, the RPN stated that they would call the charge nurse and otherwise focus on ensuring the safety of the resident and other residents in the home.

A Personal Care Aide (PCA) told inspector #568 that they were providing care for the identified resident on the day of the incident. The PCA indicated that they were familiar with the resident, the types of behaviours they exhibited and some of the strategies used to help manage them. The PCA stated that they had never actually witnessed the identified resident's responsive behaviours. Following the most recent incident where the resident exhibited escalating responsive behaviours toward staff and residents, the PCA stated that they had never seen the resident like that and were concerned for the safety of others.

Review of the resident's plan of care related to Mood State/Personal Expressions identified the resident as having unpredictable responsive behaviours. A number of interventions were documented to address these behaviours. Review of progress notes for the identified resident during a three and a half month period identified ten incidents of responsive behaviours that posed a risk to staff and/or residents.

A RPN told Inspector #568 that until very recently they worked on the neighbourhood where the identified resident resided. When asked if the staff member was aware of a specific procedure to follow when the identified resident exhibited the responsive behaviours, they said they were aware of the strategies, but when the behaviour comes on with no warning it was more difficult and you just tried to focus on protecting yourself and the other residents.

During interviews with four PCAs and one RPN they told this inspector that they were aware of the nature of the identified resident's responsive behaviours but when asked what procedures and interventions were in place to assist the staff and residents that were at risk of harm, the staff were unsure. They indicated that if there was an incident they would call for assistance using the call bell or go to get the team lead. Otherwise, they would just try to keep the resident involved and other residents safe.

The NC and Personal Expression Resource Team (PERT) PCA told this inspector that staff receive education on the unit, participate in huddles and discussions at shift report related to managing residents with responsive behaviours. Both staff agreed that the focus with the identified resident had been on preventing the behaviours and less on procedures to respond to the heightened behaviour in order to minimize potentially harmful situations. The NC and PERT PCA acknowledged that more education was needed to ensure that there were procedures and interventions in place to assist the residents and staff who were at risk of harm or were harmed because of a resident's behaviours, to minimize the risk of potentially harmful interactions.

During an interview with the Director of Nursing (DON) and Assistant General Manager (AGM) they indicated that the identified resident had been followed closely related to their responsive behaviours. The resident was discussed regularly at their risk management meetings, was being followed by the home's Personal Expressions Resource Team and had several assessments completed

related to their behaviours. A number of strategies had been developed to prevent / manage these behaviours and a great deal of staff education had been provided with respect to identifying triggers for the resident, being aware of early signs and management strategies to minimize risk of altercations or harm to residents. Despite the education, the AGM and DON acknowledged that the response to the identified resident's physically aggressive behaviours on at least two occasions put other residents and staff in a potentially harmful situation. The AGM and DON agreed that specific procedures and interventions had not been developed and implemented for staff and residents at risk of harm, to minimize altercations and potentially harmful situations.

The scope of this issue was a pattern and the severity of harm a level two with potential for actual harm to residents. The home had a history of non-compliance in a similar area. During an inspection December 30, 2014 a Voluntary Plan of Correction was issued with respect to s. 53 (4) pertaining to the identification of behavioural triggers, development and implementation of strategies for the behaviours. A Voluntary Plan of Correction was issued again relating to s. 53. (4) and for s. 54 (b) ensuring that steps were taken to minimize the risk of altercations between residents. A Compliance Order was issued with respect to s. 54. (b) on April 18, 2016 with a compliance date of May 20, 2016. The order was complied during the follow-up inspection commencing July 12, 2016. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

Service Area Office /
Bureau régional de services : London Service Area Office