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

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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
Oct 22, 2013	2013_183135_0059	L-000572-13	Critical Incident System

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 16, 2013.

During the course of the inspection, the inspector(s) spoke with Assistant General Manager, Neighbourhood Coordinator, Physiotherapist, Kinesiologist, Registered Practical Nurse, Two Personal Care Aides, Personal Support Worker and Resident.

During the course of the inspection, the inspector(s) reviewed the critical incident, related internal investigation, resident clinical records and policy and procedure for Falls Prevention. Observations of residents were conducted in resident home areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to ensure that there was a written plan of care for resident that provided clear directions to staff and others who provide direct care to the resident.

During interviews staff confirmed that directions in the plan of care had changed related to resident's mobility.

During an interview the Assistant General Manager confirmed, her expectation that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The Licensee has failed to ensure that the resident's Substitute Decision Maker (SDM), designated by the resident/SDM was given an opportunity to participate fully in the development and implementation of the plan of care when the following occurred:

Record review revealed, resident was discharged from the physiotherapy program October 2, 2013.
As of October 16, 2013, the resident's SDM has not been notified that the resident was discharged from the home's physiotherapy program.

During an interview the Assistant General Manager confirmed, her expectation the SDM and any other persons designated by the resident/SDM be given an opportunity to participate fully in the development and implementation of the plan of care as it relates to physiotherapy. [s. 6. (5)]

3. The Licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan when the following occurred:

Resdient's post fall care plan of indicated the following interventions to prevent falls:

-Ensure call bell is within reach
-Bed alarm is activated when resident is in bed

Resident observations October 16, 2013 while resident was sleeping in bed, revealed the call bell was not within reach of the resident and the bed alarm had not been activated.

During an interview the Assistant General Manager confirmed, her expectation that

care set out in the plan of care be provided to the resident as specified in the plan. [s. 6. (7)]

4. The Licensee failed to ensure that resident was reassessed and the plan of care reviewed and revised, when the resident's care needs changed as follows:

Record review revealed that resident had not been reassessed by the Physiotherapist, nor was the plan of care revised for post fall physiotherapy interventions.

In interview with Registered Practical Nurse, she confirmed that resident had not been reassessed by Physiotherapist and staff were unaware of what physiotherapy interventions needed to be in place to help prevent any future falls.

During an interview the Assistant General Manager confirmed, her expectation that residents be reassessed and the plan of care be reviewed and revised, when the resident's care needs change. [s. 6. (10) (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 residents plan of care provide clear directions to staff and care is provided as per the plan of care. Also ensuring residents are reassessed when care needs change and SDM's are given an opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented when the following occurred:

Resident's plan of care for Physiotherapy states the following:

Resident will receive one on one exercise program 2-3 times/week for 10-15 minutes per session to improve range of motion and teach proper transfer and positioning technique for resident and staff safety.

Review of the Coding Tool for Therapies and Resident Progress Sheet revealed, physiotherapy intervention documentation was missing on 7 occasions or 41.6% of the time for September 2013.

During an interview the Assistant General Manager confirmed, her expectation that resident's responses to physiotherapy interventions are documented. [s. 30. (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 ensuring resident's physiotherapy responses to interventions are documented, to be implemented voluntarily.

Issued on this 23rd day of October, 2013

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

Bonnie Mac Donald