Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702
centraleastdistrict.mltc@ontario.ca

A1-Amended Public Report

Report Issue Date: February 2, 2023

Inspection Number: 2022-1218-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

Long Term Care Home and City: Riverview Manor Nursing Home, Peterborough

Lead Inspector	**Inspector Digital Signature**
Sheri Williams (741748)	Sheri A Williams Digitally signed by Sheri A Williams Date: 2023.02.02 16:27:34 -05'00'

Additional Inspector(s)
Lynda Brown (111)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 14 -18, 2022.

The following intake(s) were inspected:

- Intake: #00002731-related to improper/Incompetent treatment of residents.
- Intake: #00003920-related to an alleged abuse incident.
- Intake: #00006929-related to a medication incident/adverse drug reaction
- Intake: #00007950-related to an alleged abuse incident.
- Intake: #00012827-related to a disease outbreak
- Intake: #00007675-related to an alleged abuse incident.
- Intake: #00007075-related improper care/incompetent treatment.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee failed to ensure the Director was notified of the results of the investigation into an alleged abuse incident immediately upon completion of the investigation.

Rationale and Summary

An allegation of abuse involving a Personal Support Worker (PSW) towards two residents, was reported to the home. The home completed an internal investigation. The Administrator confirmed the results of the investigation were not reported to the Director.

Failing to report the outcome of the investigation for allegations of abuse incidents to the Director may result in a risk of harm to residents.

Sources: Critical Incident Report (CIR), home's investigation, residents' health records and interview with Administrator.
[111]

WRITTEN NOTIFICATION: Notification of incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (2)

The licensee has failed to ensure that two residents and their substitute decision makers (SDMs), were notified of the results of the home's investigation for the alleged abuse incident, immediately upon the completion of the investigation.

Rationale and Summary

An allegation of abuse by a PSW towards two residents was reported to the home and the home completed an investigation. The results of the investigation were not reported to the residents, or the residents' SDMs. The Administrator confirmed the results of the investigation had not been reported to the residents and their SDMs.

Failing to report the results of an investigation for allegations of abuse incidents may lead to further allegations not being reported and mistrust of residents and families.

Sources:

CIR, residents' progress notes, home's investigation and interview of a resident and the Administrator
[111]

WRITTEN NOTIFICATION: Evaluation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 106 (b)

The licensee failed to ensure that an annual evaluation of every incident of abuse or neglect of a resident at the home was undertaken to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Rationale and Summary

There were a number of alleged abuse or neglect incidents that had occurred in the home throughout the year. There was no documented evidence that an evaluation of the incidents of abuse or neglect of residents was completed to determine what changes or improvements were required to prevent further occurrences. The Administrator confirmed that no annual evaluation of the incidents had been completed in the home.

Failing to complete an annual evaluation of incidents of alleged, suspected or witnessed, incidents of abuse or neglect of residents may lead to a lack of changes and improvements required to prevent further occurrences.

Sources: Zero Tolerance of Abuse and Neglect of resident's policy and interview with the Administrator.
[111]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record is kept in the home that included the nature of each verbal complaint received by a resident in the home.

Rationale and Summary

A verbal complaint was received from a resident for allegations of abuse incidents towards two residents. The Administrator indicated they keep copies of all verbal and written complaints received in the complaints binder. Review of the complaints binder did not include the verbal complaint received from a resident.

Failing to document a verbal complaint received from a resident did not allow for appropriate trending and analysis of complaints received in the home.

Sources: CIR, complaints binder and interview of Administrator.
[111]

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (3)(a)

The licensee has failed to ensure that all verbal and written complaints received by home were reviewed and analyzed at least quarterly for trends.

Rationale and Summary

Three complaints of alleged abuse incidents were received by the home. The Administrator indicated all verbal and written complaints were kept in the home's complaints binder, and confirmed none of these complaints were included, and they had not completed any review or analysis of the complaints in 2022.

Failing to complete a review and analysis at least quarterly of all verbal and written complaints received by the home does not provide an opportunity to assess for trends or improvements that may be required in the home.

Sources: CIR, complaints binder and interview of Administrator.
[111]

WRITTEN NOTIFICATION: Binding on licensees

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to ensure they carried out every operational or policy directive that applies to the long-term care homes specifically, the licensee did not follow the Minister's Directive related to screening of visitors. Licensees are required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

Rationale and Summary

An Inspector entered the home and failed the screening app upon entry. There was no monitoring completed related to failing screening. The Infection Prevention and Control (IPAC) lead confirmed they were not reviewing screening results daily and were reviewing them 24 hours later. The Director of Care (DOC) stated that allowing visitors into the home who fail screening posed a risk to residents in the home.

Failing to monitor the screening of visitors who fail screening upon entering the home placed residents at risk of transmission of Infection.

Sources: Minister's Directive for Covid-19 Response Measures for Long Term Care homes, observation Screening App, Interviews with RPN and DOC.
[741748]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 147 (3)

The licensee failed to ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary

Two Critical Incident Reports (CIR) were submitted to the Director for medication incidents, involving a Registered Practical Nurse (RPN) related to late administration of prescribed high-risk and time-critical medications. The DOC and RPN both confirmed the home was not completing quarterly medication evaluations including review of medication incidents.

Failing to complete interdisciplinary quarterly evaluations of the medication management system including medication incidents resulted in additional medication incidents involving an RPN and risk to the health and wellbeing of the residents.

Sources: CIR, Medication Incident Reports, Professional Advisory Committee (PAC) minutes, Annual Professional Committee Report, and Interviews of DOC and RPN. [741748]

WRITTEN NOTIFICATION: Administration of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (2)

1.The Licensee failed to ensure that drugs were administered to residents in accordance with directions for use specified by the prescriber.

Rationale and Summary:

A CIR indicated multiple residents did not receive their medications as specified by the prescriber. These high risk and time-critical medications were not administered in a timely manner. Some medications were administered two to four hours later, or too close together (within an hour apart), or not administered at all. The RPN no longer works at the home

The DOC and RPN both stated the medication incidents could have resulted in a serious risk to the residents.

Failing to administer prescribed medications to residents may result in serious risk of harm.

Sources: CIR, Medication Incident Reports, Interviews with DOC and RPN.
[741748]

2. The licensee failed to ensure that drugs are administered to residents in accordance with directions for use specified by the prescriber.

Rationale and Summary:

A CIR indicated there was a medication incident wherein residents had not received their 0800 hrs medications in accordance with directions for use specified by the prescriber. The residents were not administered their high-risk, time-critical medications by the RPN as specified.

The DOC and RPN confirmed medications that were not administered according to prescriber directions may have resulted in serious harm to the residents.

Failing to administer medications according to prescriber directions put residents at risk of serious harm.

Sources: CIR, Medication Incident Reports, Medication administration records, and Interviews with DOC and RPN.
[741748]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2

The licensee has failed to ensure that an alleged abuse incident was immediately reported to the Director.

Rationale and Summary

A complaint was received by the Director regarding an alleged abuse incident. Another staff member documented they reported the incident to the DOC because they considered it an abuse incident. The DOC confirmed awareness of the incident but did not report the incident to the Director as they did not feel the incident was considered an abuse incident.

Failing to immediately report an alleged abuse incident resulted in the allegations not being investigated and risk of harm to the resident.

Sources: resident's health record, interviews of a resident, staff, and the DOC
[111]

WRITTEN NOTIFICATION: Notification re incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 104 (1) (a)

The licensee failed to ensure that the resident substitute decision maker (SDM) was immediately notified of an alleged abuse incident.

Rationale and Summary

The DOC was notified of an alleged abuse incident and confirmed the SDM for the resident had not been informed of the incident, as they did not feel the incident was considered abuse.

Failing to ensure that the SDM for the resident was notified of an alleged abuse incident may lead to distrust that the home is not investigating allegations of abuse.

Sources: Resident health record, and interview of resident, staff, and the DOC.
[111]

COMPLIANCE ORDER CO #001 Promote Zero Tolerance

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must comply with FLTCA, 2021. s. 25 (1)

Specifically the licensee shall:

1.Educate the DOC and RN #112 on what constitutes verbal and/or emotional abuse and including their roles and responsibilities related to completing an assessment of the resident and investigations for allegations of same.

2.Keep a documented record of the retraining including the date it was provided and make available to the inspector upon request.

Grounds

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident regarding investigations.

Section 2 under Ontario Regulation 246/22 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity, or self-worth, that is made by anyone other than a resident.

A complaint was received by the Director regarding an alleged staff to resident verbal

abuse incident towards resident. The PSW and resident were heard arguing with each other. A witness reported the incident to the DOC as they considered the incident abuse, and the resident was upset regarding how rudely the PSW had spoken to them. The home was to complete a mandatory report checklist as part of the investigation which included the details of the allegation, who was to be notified, evaluation procedures and dates each of the tasks were completed. There was also to be witness statements obtained. There was no checklist completed for this allegation, and no documented witness statements obtained. The DOC confirmed awareness of the incident but did not investigate the incident, and the SDM of resident had not been informed of the incident, as they did not feel the incident was considered abuse.

Failing to ensure the home's policy was complied with for allegations of staff to resident abuse towards a resident related to investigations lead to lack of actions being taken to respond to the allegations.

Sources: resident health record, interview resident #002, home's investigation records, Zero Tolerance of abuse and neglect of resident's policy (OP-AM-6.0-reviewed March 30, 2022), Investigation Procedures policy (OP-AM-6.3/reviewed March 30, 2022) and interview of Administrator.
[111]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident regarding investigations.

There was an alleged staff to resident verbal abuse. The allegation had been initially reported to the RN who did not assess the resident to determine if the allegation was founded or report to their manager. The allegation was not investigated until a later date, when the resident reported the allegation. The home was to complete a mandatory report checklist as part of the investigation which included the details of the allegation, who was to be notified, evaluation procedures and dates each of the tasks were completed. There was no checklist completed for this allegation. There were no documented witness statements obtained and the response letter to the complainant did not include the outcome of the investigation or actions taken to resolve the complaint as per the home's policy.

Failing to ensure the home's policy was complied with for allegations of staff to resident abuse towards a resident related to investigations leads to residents involved in the allegations not being appropriately assessed, all required notifications completed and allegations appropriately responded to.

Sources: CIR, residents health records, interview of resident, home's investigation, Zero Tolerance of abuse and neglect of residents, Investigation Procedures, and interview of Administrator.
[111]

This order must be complied with by February 17, 2023

.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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