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

Division de la responsabilisation et de la performance du système de santé
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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
Feb 14, 2014	2014_292553_0003	001159-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

THORNTONVIEW
186 THORNTON ROAD SOUTH, OSHAWA, ON, L1J-5Y2

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

MATTHEW STICCA (553)

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): February 4, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Practical Nurse (RPN), Health Care Aide (HCA), RAI Coordinator, and 2 Residents.

During the course of the inspection, the inspector(s) Reviewed health records of two residents, observed care provided to resident(s), observed resident to resident and staff to resident interactions, toured the home and reviewed documentation and policies to Dementia care.

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

Findings of Non-Compliance were found during this inspection.

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. 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 failed to identify behavioural triggers for Resident #1 who demonstrated responsive behaviours and strategies were not developed and implemented to respond to these.

An unwitnessed incident of resident to resident physical aggression occurred between Resident #1 and Resident #2 resulting in injury to Resident #2.

Review of progress notes for Resident #1 for a specified two month period indicated:
-Resident #1 displayed agitated and physical aggressive responsive behaviours thirteen times over a two month period.
-Strategies used to manage these responsive behaviours included PRN psychotropic medication administration.

2. Review of plan of care for Resident #1 did not identify behavioural triggers for Resident #1 other than behaviours exhibited during personal care.

The CI indicated in the analysis and follow-up section that the BSO team would create a plan for Resident #1's responsive behaviour and identify interventions on the plan of care.

An interview conducted with a Behavioural Supports Ontario (BSO) team member indicated that Resident #1 was not assessed by BSO until approximately two months after the incident between Resident #1 and Resident #2.[s. 53. (4) (b)]

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Issued on this 14th day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
MATT STICCA #553