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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2015	2015_378116_0011	001852-14/T-1981-15	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

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON M4E 2V6

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

SARAN DANIEL-DODD (116)

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): June 11, 12, 15,16 and July 7, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), resident service coordinator, environmental service manager (ESM), psychogeriatric mobile team nurse at Toronto General Hospital, behavioural support outreach nurse at Toronto Western Hospital, registered staff members, personal support workers (PSWs) and residents.

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 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

The written plan of care for resident #001 revealed the potential for injury to self and others as evidenced by engaging in high risk behaviour outside of the facility which trigger responsive behaviours upon return to the home.

A review of the resident's health record and interviews held with several staff members and members of the management team identified that they had knowledge of resident #001 engaging in high risk behaviours outside of the home and has been observed with impaired judgement on several occasions within the home.

On an identified date, the inspector and two staff members observed and retrieved identified items associated with resident #001's high risk behaviour.

The written plan of care does not outline measures for monitoring the identified items. Interviews held with registered staff, PSWs, the DOC and E.D confirmed that the plan of care does not set out clear directions for the monitoring of the identified items for resident #001. [s. 6. (1) (c)]

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 the plan of care sets out clear directions to staff and others who provide direct care to resident #001 regarding the storage and consumption of identified items, to be implemented voluntarily.

WN #2: 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 is complied with.

The licensee's policy #LTC-A-80 states the following:
- the physician and/or nurse will discuss the risks of identified items consumed specific to the resident's medical condition.
- The identified items must remain in the care and control of staff in a locked cabinet with the resident's name on it.

On an identified date, the inspector and two staff members observed and retrieved identified items associated with resident #001's high risk behaviour.

Although staff members were aware of the resident's usage of the identified item, there were no procedures put in place to monitor the consumption of the identified item by resident #001.

Interviews held with registered staff members and the DOC confirmed that there was no physician's order in place for resident #001 to consume the identified item and the identified item was not kept under the care and control of staff in a locked cabinet. [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 the licensee's policy (Index# LTC-A-80) is complied with, 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 has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

The written plan of care for resident #001 revealed the potential for injury to self and others as evidenced by engaging in high risk behaviour outside of the facility which trigger responsive behaviours upon return to the home. A review of the resident's health record and written plan of care indicates that the resident exhibits untriggered responsive behaviours.

On an identified date, the licensee submitted a critical incident report to the Director reporting that resident #001 had an identified weapon upon his/her person over an identified period of time and made a verbal threat to a member of the management team. Upon request, resident #001 refused to relinquish the weapon.

Interviews held with identified staff members revealed that the resident was observed with the weapon within his/her possession on an identified number of occasions. A review of the health record revealed and interviews held with identified staff members and the DOC confirmed that interventions should have been implemented and initiated upon the homes knowledge of the identified weapon to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54. (a)]

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 by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

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Issued on this 19th day of August, 2015

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

Original report signed by the inspector.