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
Jun 2, 2014	2014_299559_0010	T-523-14	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

ANN HENDERSON (559)

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): April 11, 14, 15, 2014.

During the course of the inspection, the inspector(s) spoke with executive director, director of care, staff educator, registered staff, personal support workers (PSW), housekeeping staff and a family member.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed educational records related to responsive behaviors.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse.

Resident #002's plan of care identified the resident as exhibiting verbal aggression and agitation towards residents and staff.
A review of resident #002's progress notes revealed 51 incidents of verbal agitation towards staff and co-residents.
An altercation occurred between resident #001 and resident #002. Resident #001 was pushed by resident #002 to the ground. Resident #001 sustained a fractured right hip, was transferred to hospital for surgery and subsequently passed away.
Staff interviews revealed both residents had severe dementia and required monitoring during the shift. Resident #001 and #002 were known to become physically aggressive and had a tendency to strike out at co-residents if they were in the way.
The PSW 6 revealed he/she was to "keep an eye on the lounge area" and that he/she was in the lounge at the time of the incident but did not see what had happened as he/she had her back turned away from the residents. Registered staff revealed that there is a daily assignment sheet and PSW 2 and PSW 6 are designated to be in the lounge area alternately, monitoring at all times.
Registered staff and the DOC confirmed that the expectation is for the assigned PSW to monitor these residents when they are in the lounge to protect the residents from abuse by anyone. [s. 19. (1)]

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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent minimize or respond to the responsive behaviors are developed to meet the needs of residents with responsive behaviors.

Resident #002's plan of care identified the resident as exhibiting verbal aggression and agitation towards residents and staff.
A review of the resident #002's progress notes revealed 51 incidents of verbal agitation towards staff and co-residents.
An altercation occurred between resident #002 and resident #001 and the police and the coroner were involved. Resident#001 was transferred to hospital with a fractured hip and subsequently, passed away.
A second altercation occurred between resident #002 and resident #004, resulting in police involvement. Resident #002 was sent to the hospital for further assessment for a laceration to his/her forehead and 1:1 monitoring of resident #002 was started.
A review of the resident's written care plan used by the direct care staff did not identify resident #002's verbal aggression and agitation, however direct care staff are verbally directed by the registered staff to monitor and document his/her behaviors on point of care (POC).
Direct care staff indicated that they will attempt to redirect resident #002 when he/she becomes agitated, however there are no techniques developed to respond to his/her responsive behaviors.
Registered staff indicated that resident #002was referred to the Geriatric Mental Health Outreach Program (GMHOP), and was to be assessed by the GMHOP one

week later but the resident was unavailable as he/she was being assisted with care. A further assessment was completed three weeks later and medication changes were suggested. Approximately six weeks later, the GMHOP assessment indicated that despite an initial improvement the resident was still not stabilized. Direct care staff reported that on this date the resident had an unprovoked verbal outburst stating "I will kill you".
Registered staff interviews revealed that residents with responsive behaviors are to be monitored using a behavior tracking tool and residents are to be referred to outside behavioral support teams for further assessment.
Staff interviews indicated that they were verbally directed by the registered staff to monitor the resident's behaviors and agitation and document in POC. The resident was reassessed by GMHOP three months later recommending that the staff continue to approach him/her using the Gentle Persuasive Approach (GPA) approach, to provide medications as ordered and consider encouraging the use of rewards that the resident likes.
The DOC when interviewed revealed that the home does not use GPA and that staff are directed during the shift report by the registered staff to monitor responsive behaviors in POC, respond by distracting and follow the other recommendations by the GMHOP.
The DOC confirmed there were no written strategies, including techniques and interventions to respond to the resident responsive behaviors. [s. 53. (1) 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 , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to report immediately to the Director of abuse of a resident by anyone that resulted in harm to the resident.

The Long-Term Care Homes Act 2007, defines abuse as the use of physical force by a resident that causes physical injury to another resident. An altercation between two residents occurred, resident #001 was pushed by resident #002 to the floor sustaining a hip fracture. The resident passed away as a result of complications of the fracture. A review of the clinical records indicated that the home reported the incident to the Director two days after the altercation. The DOC indicated in an interview that the altercation was not considered abuse and therefore did not report the incident immediately to the Director. [s. 24. (1)]

Issued on this 2nd day of June, 2014

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