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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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 16, 2014	2014_293554_0009	O-000472-13	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

REACHVIEW VILLAGE
130 REACH STREET, UXBRIDGE, ON, L9P-1L3

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

KELLY BURNS (554)

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): March 13, 14 and 28, 2014

Critical Incident Inspection pertaining to Log(s) #000472-13 and #001164-13

During the course of the inspection, the inspector(s) spoke with Executive Director(ED), Director of Care(DOC), Assistant Director of Care(ADOC), Registered Nursing Staff, Personal Support Workers, and Residents

During the course of the inspection, the inspector(s) conducted a brief tour of the home, reviewed clinical health records specific to three resident's, incident reports, the home's briefing notes related to log #000472-13 and #001164-13, reviewed policies specific to: dementia care, resident incidents, investigation of abuse, resident non-abuse, reporting and complaints; and reviewed staff training records relating to zero tolerance for abuse, resident bill of rights and mandatory reporting

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Related to Log #O-001164-13 for Resident #001:

The licensee failed to comply with LTCHA, 2007, s. 23(1)(a), to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated.

A Critical Incident Reported was submitted by the Licensee on an identified date, indicating Staff to Resident Abuse.

The Director of Care(DOC), during an interview on March 13, 2014, indicated that Staff #152 reported, that Staff #153 was witnessed being rough and aggressive towards Resident #001. Staff #152 reported that the rough transfer caused a skin tear to the resident's arm. DOC indicated that Staff #152 had indicated that the incident occurred during an identified date and time.

A review of the home's Briefing Notes, which documents the homes' investigation of the allegation, concluded that Staff #153 was not interviewed as to the allegation of Abuse until 12 days later. The notes indicate that the Registered Nurse and Registered Practical Nurse working on the date specified were not interviewed until six days later.

DOC indicated the interview with Staff #153 was not conducted immediately, as DOC was out of the home for several days after the reported incident.

The home's policy Resident Non-Abuse (LP-B-20-ON), directs that an immediate and thorough investigation of reported alleged, suspected or witnessed abuse or neglect will be initiated by the home's Executive Director or designate.

The home's Tool Kit for Conducting an Alleged Abuse Investigation (LP-C-20-Appendix A), directs that interview's with the accused and witnesses are to be conducted within 24 hours.

The licensee did not investigate the alleged, suspected or witnessed Abuse immediately. [s. 23. (1) (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 every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #2: 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. Related to Log #001164-13, for Resident #001:

The licensee failed to comply with LTCHA, 2007, s.24(1)2. 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, specific to: 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.

A Critical Incident Report was submitted by the Licensee on an identified date indicating Staff to Resident Abuse.

The written description of the unusual occurrence, on the CI report, indicates that Staff #152 brought forth concerns regarding Staff #153's rough handling of Resident #001 during an incident on a specified date. The allegation indicated the rough handling resulted in an injury to a resident. The alleged abuse was not reported by Staff #152 to the Director of Care (DOC) and Executive Director (ED) until four days later.

Staff #152 did not report concerns of rough handling to the registered nursing staff during the shift identified; the only report made to the registered staff was that Resident #001 had sustained an injury during a transfer.

Staff #152 did not indicate the reason for the delay in reporting the allegation of suspected or witnessed Abuse, to the DOC or ED.

The DOC and Assistant Director of Care (ADOC) indicated that staff education is conducted upon hire and annually thereafter specific to: Resident Non-Abuse, Resident Bill of Rights, Power Imbalance Relationships between staff and residents and Mandatory Reporting. DOC and ADOC indicated that Staff #152 had received training in the previous year, but were unable to provide specific dates of the education.

A plaque is posted in the home's front foyer indicating staff's responsibility for reporting alleged, suspected or witnessed abuse under Section 24 of the Long Term Care Homes Act. [s. 24. (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 ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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. Related to Log #O-000472-13, for Resident #002 and #003:

The licensee failed to comply with O. Reg. 79/10, s. 53(4)(a), by ensuring that, for each resident demonstrating responsive behaviours that behavioural triggers are identified.

The home submitted a Critical Incident(CI) on an identified date with regards to resident to resident abuse; the CI described an altercation between Resident #002 and #003. As per the CI, Resident #002 hit Resident #003; Resident #003 then grabbed Resident #002, causing an injury. Staff intervened and separated residents, situation was de-escalated.

Related to Resident #002:

a) Progress Notes reviewed for Resident #002, for a specific time period indicated responsive behaviours exhibited by resident including: resistive to care and treatments, and aggression.

Review of the care plan for Resident #002 for the above time period, indicated there is no evidence that behavioural triggers have been identified related to responsive behaviours, specifically aggression, despite a physical altercation with Resident #003.

Director of Care(DOC) indicated, on March 13, 2013 that Resident #002 does have a tendency for aggression, if provoked or feels threatened.

Related to Resident #003:
b) Progress Notes reviewed for Resident #003, for a specific time period of indicated behaviours exhibited by resident as: resistance to care, meals, medications, verbal aggression, and physical aggression.

DOC indicated that Resident #003 has a history of verbal aggression and a potential for physical aggression

Review of the care plan for Resident #003 for the above time period, indicated there is no evidence that behavioural triggers have been identified related to responsive behaviours, specifically verbal and or physical aggression. [s. 53. (4) (a)]

2. Related to Log #O-000472-13, for Resident #002 and #003:

The licensee failed to comply with O. Reg. 79/10, s. 53(4)(b), by ensuring that, for each resident demonstrating responsive behaviours that strategies are developed and implemented to respond to behaviours.

a) Related to Resident #002
Interviews with Registered Staff, Personal Support Workers(PSW), Director of Care (DOC) and Assistant Director of Care(ADOC) for Resident #002 indicated the strategy implemented to respond to resident's responsive behaviours when resistive to care, treatment and medications is to re-approach.

The care plan for the period reviewed, does not identify strategies for responsive behaviours specific to resistance to care and or treatments/medications nor aggression, other than to reapproach.

b) Related to Resident #003
Interviews with Registered Staff, PSW's, DOC, ADOC for Resident #003 indicated the strategy implemented to respond to resident's responsive behaviours are to monitor, document incidents of behaviours and to allow resident to settle or calm down on own.

The Director of Care indicated that the home has normalized Resident #003's responsive behaviours.

The care plan for the period reviewed, does not identify strategies for responsive behaviours especially with regards to aggression (verbal and or physical) directed towards co-residents, families, visitors and staff despite two separate incidents of physical aggression, other than to allow to resident to settle.

The home's policy Dementia Care (LTC-E-100) directs that care planning will reflect individualized and flexible approaches that include both non-pharmacological and pharmacological interventions and referrals to specialists, when a resident is experiencing challenging and or disruptive behaviours. [s. 53. (4) (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 each resident demonstrating responsive behaviours has behavioural triggers identified, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, S.O. 2007, s.76(4) by ensuring that all staff have received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents.

The DOC could not provide dates during 2013, in which Staff #152 and #151 received education in relation to zero tolerance of abuse and neglect of residents. DOC was unable to locate training records for the above two staff. [s. 76. (4)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. Related to Log #O-001164-13, for Resident #001:

The licensee failed to comply with O. Reg. 79/10, s.104(3), if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director), including:

4. Analysis and follow up action, including immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

The home upon becoming aware of the allegation of abuse, submitted a Critical Incident Report on a specified date. An amendment was made to the report on six days later, indicating investigation remains in progress and clarification was made as to which staff member was accused of the allegation of abuse.

The Critical Incident Report contains an entry, dated seven days after the submission, written by a member of the CIATT team, requesting the licensee amend CI upon completion of investigation.

During interviews with the home, the DOC indicated that the home had concluded it's investigation.

No amendments have been made to CI to indicate the outcome of the investigation. [s. 104. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Related to Log #O-000472-13, for Resident #003:

The licensee failed to comply with O. Reg. 79/10, s. 131 (2) by ensuring drugs are administered in accordance with directions for use specified by the prescriber.

A review of the physician's orders indicates that an order for an anti-anxiety medication was discontinued on an identified date, and another sedative was prescribed.

The quarterly physician's review for the period reviewed, indicates an order for the anti-anxiety to be given daily at bedtime. The medication administration record(MAR) does not demonstrate that this medication was given daily as ordered by the attending physician.

The medication does not appear on the quarterly physician's review for following quarter, nor is there a written order discontinuing the medication following the order date specified.

The Director of Care indicated that it appeared as if there may have been an error or discrepancy when reviewing the quarterly medication review, but was unsure; DOC indicated that the registered staff should have clarified the order versus not administering the medication, and further indicated that such is considered a medication error.

The Director of Care indicated that the discrepancy would be reviewed with the Attending Physician and the Registered Staff. [s. 131. (2)]

Issued on this 16th day of June, 2014

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