Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2020	2020_788721_0013	006762-20, 012105-20	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Village on the Ridge
9 Myrtle Street RIDGETOWN ON N0P 2C0

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

MEAGAN MCGREGOR (721), CASSANDRA TAYLOR (725)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 25, 26, 29 and 30, and July 2, 6, 7, 8, 9 and 10, 2020.

The following Complaint and Critical Incident (CI) intakes were completed within this inspection:

Log #006762-20 related to concerns with falls prevention, toileting and continence care, medication consent and resident neglect; and
Log #012105-20/CI #2765-000007-20 related to allegations of resident neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Acting Executive Director, the Director of Care, a Regional Director of Operations, a Registered Nurse, a Physiotherapist Assistant, two Health Care Aides, two Security Guards and residents.

The Inspectors also observed staff interactions with residents and the care being provided to residents, reviewed clinical records and plans of care for the identified residents and reviewed the home's investigation notes related to the incident.

This inspection was conducted concurrently with Complaint Inspection #2020_747725_0003.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care (MLTC) received multiple complaints during a specific period of time related to concerns about resident #001 having multiple falls since their admission to the home and falls prevention interventions not being in place as per their plan of care.

During the course of the inspection resident #001 was observed to have a specific intervention in place.

A review of resident #001's Assessments section in PointClickCare (PCC) showed a falls risk assessment stating they were at high risk for falls. It was documented that resident was to have this specific intervention in place related to falls prevention.

A review of resident #001's Care Plan in PCC showed this specific intervention was implemented on a specific date related to a focus of being screened at high risk for falls.

A review of resident #001's Progress Notes and Risk Management section in PCC showed documentation indicating they were to have this specific intervention in place related to falls prevention and on a specific date and time staff observed the resident on the floor and this specific intervention was not in place.

During interviews with Health Care Aide (HCA) #104 and HCA #105 they stated they would look at a resident's care plan to find out what their care needs were. Both HCAs said that resident #001 was at risk for falls and were to have this specific intervention in place related to falls prevention.

During an interview with Director of Care (DOC) #101 they stated resident #001 had a history of falls and would often exhibit specific behaviours which put them at risk for falls. DOC #101 said resident #001 had this specific intervention in place for falls prevention. Inspector #721 and DOC #101 reviewed the identified progress note in resident #001's clinical record which stated staff observed the resident on the floor and this specific intervention was not in place. When asked why this specific intervention was not in place at the time of the fall, DOC #101 stated they didn't know and would expect that it should have been in place at this time.

The licensee failed to ensure that the care set out in the plan of care related to falls

prevention for resident #001 was provided to the resident as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The MLTC received a complaint related to an alleged incident of neglect involving resident #001 which occurred on a specific date. The home also submitted Critical Incident System report #2765-000007-20 to the MLTC related to this incident.

A review of resident #001's clinical record in PCC showed progress notes from the specific date of the alleged incident indicating that the resident was exhibiting specific responsive behaviours. Further review of the documentation indicated that the resident's care plan stated that if the resident had escalating behaviours the family would be contacted.

During an interview with the Acting Executive Director they indicated that the residents actions on this specific date were considered to be a responsive behaviour and that staff should have followed the care plan and contacted the family.

The licensee has failed to ensure that the care set out in the plan of care related to responsive behaviours for resident #001 was provided to the resident as specified in their plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of July, 2020

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

Original report signed by the inspector.