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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2015	2015_248214_0010	H-001674-14	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

DOVER CLIFFS
501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

CATHY FEDIASH (214)

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 15, 16, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Registered Staff, Personal Support Workers (PSW) and Activation staff. The inspector also reviewed relevant clinical records, policies and procedures, training records, program evaluations, the critical incident submitted by the home and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

A review of resident #100's current written plan of care indicated that interventions to manage their responsive behaviour included staff would complete safety checks every 15 minutes. The plan also indicated that the resident had one to one supervision. An interview with the ED confirmed that the resident did have one to one continuous staffing currently in place and that the plan did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of resident #100's Resident Assessment Protocol (RAP) with an identified completion date of November 2014, indicated that the resident's behaviours had increased and that the behaviours exhibited towards specific residents was not due to delirium. A review of this resident's current written plan of care indicated that the resident exhibited the identified behaviours due to their cognitive impairment and included interventions to manage this; however; these interventions were not created until 18 days after the assessment. The ED confirmed that the resident's plan of care was not reviewed and revised when their care needs changed. [s. 6. (10) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented

A) A review of resident #100's clinical records indicated that on an identified date in June 2014, the resident was interviewed about an altercation with their room-mate that had occurred the previous evening. The resident confirmed there were no injuries, just a lot of noise. A review of the resident's clinical records did not contain any documentation of this altercation that was to have occurred the previous day.

B) A review of resident #100's progress notes indicated that on an identified date in November 2014, the resident was observed to have touched resident #300 and that staff escorted the two residents away from one another. A review of the progress notes for resident #300 indicated that no documentation regarding this incident or any actions taken towards resident #300 was documented.

An interview with the ED confirmed that it was an expectation of the home to document all incidents and any responsive behaviours in the resident's progress notes of their clinical record and that not all actions, interventions or the resident's response to any interventions, were documented. [s. 30. (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 ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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. The licensee did not ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #100's clinical record indicated that the resident demonstrated responsive behaviours.

A) According to the resident's progress notes on an identified date in September 2014, documentation indicated that the resident was very agitated at the beginning of the shift due to a co-resident's behaviour and equipment that was in place for this co-resident.

Staff documented that they explained the reason for the co-resident's equipment; however; no documentation was included regarding the resident's response to the intervention provided.

B) According to the resident's progress notes on an identified date in September 2014, in the early morning hours documentation indicated that the resident was upset with a roommate; however; no documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

C) According to the resident's progress notes on an identified date in September 2014, at the lunch hour, documentation indicated that the resident was physically abusive with another resident. Staff documented that a referral was faxed to Specialized Geriatric Services and Behaviour Support Ontario; however; no documentation was included regarding what actions were taken to respond to the needs of the resident at the time or the resident's response to any interventions that were implemented.

D) According to the resident's progress notes on an identified date in September 2014, following the lunch hour, documentation indicated that the resident was disturbed by their roommate who was being physically abusive towards the staff and that the resident responded with striking out at the roommate. Staff documented that the Personal Support Worker (PSW) was not able to intervene at the time as the roommate had their arm in the resident's tight grip; however; no documentation was included regarding what actions were taken to respond to the needs of the resident at any time during this altercation or the resident's response to any interventions that were implemented.

E) According to the resident's progress notes on an identified date in October 2014, documentation indicated that the resident was found sitting on resident #200's bed touching the co-resident inappropriately. Staff documented that they informed the resident that their actions were unacceptable and asked them to leave the room; however; no documentation was included regarding the resident's response to this intervention.

F) According to the resident's progress notes on an identified date in October 2014, documentation indicated that the resident was found in another co-resident's room which caused upset to this co-resident. The co-resident tried to push the other resident out of the room. Staff documented that they redirected the resident out of the room and explained that they were not allowed to go into this co-resident's room; however; no

documentation was included regarding the resident's response to this intervention.

G) According to the resident's progress notes on an identified date in November 2014, documentation indicated that the resident was observed by the nursing staff to be touching resident #300 inappropriately. Staff documented that they informed the resident not to touch and then escorted the two residents away from one another; however; no documentation was included regarding the resident's response to these interventions.

H) According to the resident's progress notes on an identified date in November 2014, documentation indicated that staff observed the resident touching resident #400 inappropriately. Staff documented that front line nursing staff informed the resident that their action was inappropriate and staff then separated both residents; however; no documentation was included regarding the resident's response to these interventions.

An interview with the ED confirmed that documentation was not completed regarding actions taken to respond to the needs of the resident or the resident's response to any interventions that were implemented, for the incident's noted above. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, that 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of the home's policy titled, Resident Non-Abuse-Ontario (LP-C-20-ON and dated with a revised date of September 2014) indicated the following:

i) Under Mandatory Reporting, any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately.

A) A review of resident #100's clinical records indicated that on an identified date in November 2014, they were observed by nursing staff to have touched resident #300 in a fashion that may be considered abuse.

B) A review of resident #100's clinical records as well as the critical incident submitted by the home indicated that on an identified date in November 2014, they were observed by nursing staff to have touched resident #400 in a fashion that may be considered abuse.

C) A review of resident #100's Minimum Data Set (MDS) coding dated on an identified date in November 2014, indicated under Section E. Mood and Behaviour Patterns that the resident was coded as having demonstrated Socially Inappropriate/Disruptive Behavioural Symptoms that occurred one to three days in the last seven days and that the behaviour was easily altered. A review of the MDS Resident Assessment Protocol (RAP) dated on the same identified date in November 2014, that was triggered as a result of the above coding, indicated that the resident's behaviours have increased and that the behaviours exhibited were inappropriate touching of co-residents and that this behaviour was not due to delirium. A review of resident #100's clinical record indicated that on an identified date in October 2014 and two identified dates in November 2014, the resident demonstrated behaviours towards co-resident's.

An interview with the ED confirmed that they were not made aware of these incidents of responsive behaviours that were exhibited by resident #100 until an identified date later in November 2014; were not aware of the above documentation that was completed 13 days prior to the last two incident's and that staff documenting these incident's did receive the required training regarding reporting requirements of any suspected abuse. The ED confirmed that the home did not comply with their policy to promote zero tolerance of abuse and neglect of residents.

ii) Under Mandatory Reporting, The LTCHA provides that any person who has reasonable grounds to suspect than any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care (the "Ministry"):

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.

A) A review of resident #100's clinical records indicated that on an identified date in October 2014, they were observed by nursing staff to touch resident #200 inappropriately which may have been considered abuse.

B) A review of resident #100's clinical records indicated that on an identified date in November 2014, they were observed by nursing staff to have touched resident #300 inappropriately which may have been considered abuse.

An interview with the Executive Director (ED) confirmed that they were not made aware of the above incidents until an identified date later in November 2014. The ED confirmed that the home did not report these incidents to the Director of the Ministry of Health and Long-Term Care once they became aware and did not comply with their policy to promote zero tolerance of abuse and neglect of residents. [s. 20. (1)]

WN #5: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

A review of resident #100's clinical records indicated that on an identified date in October 2014, they were observed by nursing staff to be touching resident #200 inappropriately which may have been considered abuse. An interview with the Executive Director (ED) confirmed that they were not made aware of this incident until an identified date in November 2014. The ED confirmed that the staff member who documented this incident was employed by a staffing agency and contracted through the home and that no training records in the area of the home's policy to promote zero tolerance of abuse and neglect of residents, could be located for this staff member. [s. 76. (2) 3.]

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

Issued on this 18th day of May, 2015

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

Original report signed by the inspector.