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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 22, 2017;	2017_574586_0003 (A1)	005241-17	Resident Quality Inspection

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

NORTHRIDGE
496 POSTRIDGE DRIVE OAKVILLE ON L6H 7A2

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

Ontario

Ministry of Health and Long-Term Care

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendment made due to incorrect resident number.

Issued on this 22 day of March 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 8, 9, 10, 13, 14, 15, 16, 17, 20 and 21, 2017.

The following Critical Incident System (CIS) inspections were completed concurrently with the RQI:

024000-16 - Prevention of Abuse and Neglect

029058-16 - Prevention of Abuse and Neglect

030877-16 - Prevention of Abuse and Neglect

034003-16 - Prevention of Abuse and Neglect

000265-17 - Fall Prevention and Management

003981-17 - Prevention of Abuse and Neglect

004018-17 - Responsive Behaviours

The following CIS Inquiries were completed on-site concurrently with the RQI:

031495-16 - Prevention of Abuse and Neglect

005686-17 - Prevention of Abuse and Neglect

The following Follow-up Inspections were completed concurrently with the RQI:

026669-16 - Policy

026670-16 - Pain Management

026671-16 - Medication

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Directors of Care (ADOC), Behavioural Support Ontario (BSO) staff, Resident Assessment Instrument (RAI) Coordinator, Environmental Services Manager (ESM), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), families and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed resident health records, incident investigation notes, policy and procedures, Risk Management Reports, and training records, interviewed staff and observed resident care and dining. Note that an inspector-in-training was on-site during the RQI.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Snack Observation

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

- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #003	2016_511586_0004	123
O.Reg 79/10 s. 52. (2)	CO #002	2016_511586_0004	123
O.Reg 79/10 s. 8. (1)	CO #001	2016_511586_0004	123

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 has failed to ensure that the following was developed to meet the needs of residents with responsive behaviours: written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Resident #031 had a history of sexual responsive behaviours. Progress note documentation confirmed the resident had multiple occurrences of demonstrating these behaviours. The resident did not exhibit any of these behaviours for a period of time so when the BSO RPN assessed the resident's charting, they determined the behaviours were no longer present; therefore, discharged them from the BSO program.

The BSO RPN confirmed that they resolved the "responsive behaviours" section of the resident's documented plan of care. This was removed entirely from the resident's plan of care, meaning the behaviours and interventions were removed entirely from the documented plan of care, including any of the resident's history of these behaviours. On an identified date following this, the resident sexually abused co-resident #032.

Interview with the BSO RPN confirmed that for a specific period of time, the resident did not have any information about their history of sexually responsive behaviours in their documented plan of care, which front line staff use to direct care. The BSO RPN confirmed this information should have remained in the documented plan of care to provide written strategies to staff to prevent, minimize or respond to sexually responsive behaviours. [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 ensure that the following is developed to meet the needs of residents with responsive behaviours: written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that resident #032 was protected from sexual abuse.

Resident #031 had a history of sexual responsive behaviours. Progress note documentation confirmed the resident had multiple occurrences of demonstrating these behaviours. The resident did not exhibit any of these behaviours for a period of time so when the BSO RPN assessed the resident's charting, they determined the behaviours were no longer present; therefore, discharged them from the BSO program.

The BSO RPN confirmed that they resolved the "responsive behaviours" section of the resident's documented plan of care. This was removed entirely from the resident's plan of care, meaning the behaviours and interventions were removed entirely from the documented plan of care, including any of the resident's history of these behaviours. On an identified date following this, the resident sexually abused resident #032.

Interview with resident #032 confirmed that the resident did not want the touching to occur and did not consent to it.

At the time of the incident, there was no indication in the resident's documented plan of care that they had a history of sexually inappropriate behaviours or any interventions in place to mitigate the risk toward other residents.

In an interview with the DOC they confirmed the home was aware of the resident's history of inappropriate touching, that other residents were at risk, and that the BSO had removed all interventions from the documented plan of care. The DOC acknowledged that resident #032 was not protected from sexual abuse by resident #031. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section 136(4).

The home's Drug Record was reviewed (including shipping reports and packaging slips) and numerous medications had been ordered; however, the record did not include the date of when the drugs were received by the home and did not have the signature of the person acknowledging receipt of the drug on behalf of the home.

Registered staff #105 was interviewed and confirmed that the Drug Record did not include documentation of the date that the drugs were received by the home or the signature of the person acknowledging receipt of the drugs on behalf of the home.

The ADOC was interviewed and confirmed that the home's expectation was that staff sign and date the drug order book and or sign the shipping report and packaging slip(s) and place in the Drug Record. The ADOC confirmed that the staff did not complete the documentation in the Drug Record as above. [s. 133.]

Issued on this 22 day of March 2017 (A1)

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

Original report signed by the inspector.