Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur 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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2019	2019_587129_0016	017083-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

PHYLLIS HILTZ-BONTJE (129)

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): September 17, 18, 19, 20, 2019.

During this inspection the following intake was inspected:
017083-19 - related to abuse

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Dietary Aide, Registered Practical Nurses, Assistant Director of Care/Staff Educator, Director of Care and the Administrator.

During the course of this inspection, the inspector observed residents and resident's environments, reviewed clinical records, investigative notes made by the Director of Care, the licensee's policies and program documents related to Prevention of Abuse and Management of Responsive Behaviours as well as staff training records.

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

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

- **2 WN(s)**
- **2 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. (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 resident #002's plan of care was reviewed and revised when the resident's care needs changed.

Resident #002's plan of care was not reviewed or revised when the resident's care needs changed and they demonstrated a responsive behaviour.

A plan of care related to the management of the responsive behaviour had been developed and implemented following an incident that occurred on an identified date in 2017. The plan of care included actions staff were to take if the resident demonstrated the responsive behaviour as well as monitoring strategies and reporting/documentation requirements.

Documentation made by the Director of Care (DOC) indicated that Registered Practical Nurse (RPN) #104 had resolved the above noted care plan focus on an identified date, without consultation with the interdisciplinary team. A review of the computerized clinical record verified that the responsive behaviour management care plan focus for resident #002 had been resolved on an identified date, and as a result there were no longer interventions in the plan of care related to the actions to take when resident #002 demonstrated the identified behaviour, monitoring strategies or directions for staff to report and document the responsive behaviour demonstrated by resident #002.

A review of clinical notes documented by registered staff indicated that 15 days after the above noted care plan focus had been resolved a Personal Support Worker (PSW) reported that resident #002 demonstrated the identified responsive behaviour. The DOC and a review of the clinical record confirmed that the resident's plan of care had not been reviewed or revised following this incident and a behavioural care plan focus, goal or interventions had not been added to resident #002's plan of care.

The DOC, clinical records and other records maintained by the home confirmed that resident #002's plan of care had not been reviewed or revised when resident #002 continued to demonstrate a responsive behaviour and 33 days after the above noted incident, it was observed and reported that resident #002 demonstrated the identified responsive behaviour towards a co-resident.. [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 and ensuring 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 change, to be implemented voluntarily.

WN #2: 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 resident #001 from abuse by a co-resident.

On an identified date, the licensee submitted a report to the Director under the category of abuse of a resident. The licensee amended the submitted report and indicated a co-resident was observed to demonstrate abusive behaviour towards resident #001.

Documentation included in the report to the Director indicated that resident #001 had been assessed as having experienced a cognitive decline.

At the time of this inspection two staff who were familiar with resident #001, described the resident's interactions with them as well as with other residents and indicated that based this knowledge of the resident #001, they would not have been able to communicate their wishes to the co-resident or to stop the co-resident from demonstrating the identified responsive behaviour.

The licensee failed to protect resident #001 from abuse by a co-resident when:
-they failed to have an active plan of care in place related to an identified co-resident's history of responsive behaviour that directed staff to monitor, report or document behaviour demonstrated by the co-resident,
-they failed to review or revise a co-resident's plan of care when the resident continued to demonstrate the identified behaviour, and
-resident #001 was observed to be abused by a co-resident who demonstrated a responsive behaviour on an identified date. [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 and ensuring that 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, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.