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
Oct 15, 2020	2020_661683_0015	004891-20, 006231-20, 009434-20, 014426-20	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

Ridgeview
385 Highland Road West STONEY CREEK ON L8J 3X9

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

LISA BOS (683)

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 29, 30, October 1, 2, 6, 7, 8 and 9, 2020.

The following intakes were completed during this critical incident inspection:
Log #004891-20 was related to responsive behaviours and the prevention of abuse and neglect;
Log #006231-20 was related to the prevention of abuse and neglect;
Log #009434-20 was related to falls prevention and management.

The following follow up inspection was completed concurrently with this critical incident inspection:
Log #014426-20 was related to CO #001 from inspection #2020_689586_0013 regarding LTCHA s. 6 (7)

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director, the Assistant Director of Care (ADOC), the Dietary Manager, the Resident Assessment Instrument (RAI) Coordinators, registered staff, personal support workers (PSWs) and residents.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed meeting minutes, reviewed internal audits and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
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)**

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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_689586_0013	683

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. 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 #004 was protected from abuse by resident #003.

Residents #003 and #004 were known to demonstrate responsive behaviours. Resident #003's care plan included triggers for their behaviours and interventions were in place in order to protect other residents. There was an altercation between the two residents which resulted in an injury to resident #004 that required transfer to hospital.

There was a history of a similar incident between the two residents and resident #003 was known to demonstrate behaviours towards co-residents, which put resident #004 at risk of harm/injury.

Sources: Critical Incident System (CIS) report, resident #003 and #004's clinical record, and interview with RPNs and other staff. [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 to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions were implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents

Residents #003 and #004 were known to demonstrate responsive behaviours. Resident #003's care plan included triggers for their behaviours and interventions were in place in order to protect other residents. There was an altercation between the two residents which resulted in an injury to resident #004 that required transfer to hospital.

There was a history of a similar incident between the two residents and resident #003 was known to demonstrate behaviours towards co-residents. An intervention in resident #003's plan of care was not implemented, which put resident #004 at risk of harm/injury.

Sources: CIS report, resident #003 and #004's clinical record, and interview with RPNs and other staff. [s. 55. (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 procedures and interventions are implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 19th day of October, 2020

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

Original report signed by the inspector.