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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 9, 2017	2017_626501_0005	030867-16, 030981-16, 035454-16	Critical Incident System

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

SUSAN SEMEREDY (501)

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): February 24, 27, 28, March 1 and 2, 2017.

This inspection is related to intakes #030867-16, 030981-16 and 035454-16 related to responsive behaviours and duty to protect. This inspection was conducted concurrently with inspections 2017_626501_0004 and 2017_626501_0006.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Nurse from Ontario Shores, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), physicians, Behavioural Support Services/Recreation Therapist, Substitute Decision Makers (SDMs) and residents.

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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The home has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of a Critical Incident Report (CIR) submitted to the MOHLTC on an identified date revealed resident #008 acted inappropriately with resident #009 while resident #009 was sitting in a chair in the hallway. A Behavioural Support Services referral for resident#008 was faxed to Leap of Faith Together (LOFT) at Mackenzie Health.

Record review of resident #008's medical record on the unit revealed there was a referral faxed to LOFT at Mackenzie Health on an identified date. There was no indication that an assessment had been completed. Interview with RPN #002 revealed the unit had not received a response to this request for services. After speaking with the inspector regarding this matter, RPN #002 revealed he/she had requested and obtained a copy via fax of an email which had been sent from LOFT Behaviour Support Services to the ADOC and DOC at the home on an identified date. The email indicated that services would not be provided for resident #008 at that time due to explanations found within the email.

Interview with the ADOC and DOC revealed that emails that are received from outside agencies are often sent to them and they pass these on to the home's nursing email address. The ADOC and DOC confirmed there was no accountability for nursing staff to

read and take action to these emails and both agreed this particular email was never made part of resident #008's plan of care. The ADOC and DOC confirmed that this was an area the home needed to work on as staff and others involved in the different aspects of care were not collaborating with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others who provided direct care to the resident were kept aware of the contents of the plan of care.

Review of a Critical Incident Report (CIR) submitted to the MOHLTC on identified date, revealed resident #008 acted inappropriately with resident #009 while resident #009 was sitting in a chair in the hallway. Both residents were separated following the incident and a one to one was initiated to observe resident #008. Mini-Mental State Examination (MMSE) for resident #008 indicated severe cognitive impairment and the MMSE for resident was #009 also indicated severe cognitive impairment. A Behavioural Support Services referral for resident #008 was faxed to LOFT at Mackenzie Health. Resident #008's SDM was contacted and indicated that this has been normal behaviour for the resident. A multidisciplinary meeting was held on an identified date in 2016, where it was discussed that a change in seating in the dining room could prevent recurrence as resident #008 and #009 sit beside one another.

Review of a subsequent CIR submitted to the MOHLTC on the following identified date, revealed that one to one PSW staff #012 had seated resident #008 beside #009 in the dining room and witnessed resident #008 act inappropriately with resident #009. PSW staff #012 was unaware that the residents were not to be seated beside one another.

Review of resident #008's progress notes revealed there was a multidisciplinary meeting on the above mentioned date, to discuss how to prevent recurrence of resident #008 acting inappropriately with resident #009. Interview with PSW #012 revealed he/she was not aware resident #008 and #009 were not to sit together and was only informed of this after the fact. Interview with RPN #002 and ADOC revealed the interventions discussed at the meeting, in the morning were not communicated to the one to one staff working with resident #008 in the evening which included not having resident #008 and #009 sit beside one another in the dining room.

An interview with the ADOC confirmed registered staff failed to keep the one on one staff aware of resident #008's plan of care. [s. 6. (8)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and that staff and others who provided direct care to the resident were kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #2: 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 home has failed to ensure that actions taken to meet the needs of the resident with responsive behaviours include reassessments.

Review of a Critical Incident Report (CIR) submitted to the MOHLTC on an identified date in 2016, revealed resident #008 acted inappropriately with resident #009 while resident #009 was sitting in a chair in the hallway. Review of progress notes revealed a multidisciplinary meeting was held on the day after where an identified intervention for resident #008 to help him/her express identified emotions was discussed. This intervention was to be trialed for one week and reassessed.

Review of resident #008's most current written plan of care for behaviour in which the resident's acts are characterized by inappropriate behaviour directs staff to provide the resident with distraction techniques such as what had been discussed at the above meeting. For ineffective coping related to an identified medical condition, staff are directed to provide an intervention to the resident for ability to express identified emotions for one week. As well there is direction to utilize a specific device when communicating with resident during one to one interaction due to a hearing impairment.

Observation of resident #008 on March 1, 2017, revealed the resident was wandering in the hallway and going into various rooms but not interacting with any other residents. The resident did not have any intervention as discussed in the meeting or in the plan of care.

An interview with PSW #001 revealed he/she remembers trialing resident #008 with an identified intervention but indicated the resident did not respond as expected. According to PSW #001, resident #008 likes a different intervention. An interview with RPN #002 revealed resident #008's trial was unsuccessful. The RPN also indicated that the communication device does not work as it startles the resident and he/she does not comprehend what the speaker is trying to tell him/her.

Interviews with RPN #002 and the ADOC confirmed that resident #008's interventions to meet the needs for responsive behaviours have not been reassessed. [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 actions taken to meet the needs of the resident with responsive behaviours include reassessments, to be implemented voluntarily.

Issued on this 17th day of March, 2017

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

Original report signed by the inspector.