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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2018	2018_601532_0024	029668-17, 007214-18, 009669-18, 010326-18, 014489-18, 019572-18, 024939-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Riverbend Place
650 Coronation Blvd. CAMBRIDGE ON N1R 7S6

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

NUZHAT UDDIN (532)

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): October 18, 19, 22, 23, 24, 25 and 29, 2018.

The following intakes were completed in conjunction with this inspection:
Log #029668-17, CIS #2753-000011-17 related to falls prevention.
Log #007214-18, CIS #2753-000001-18 related to resident to resident abuse.
Log #009669-18, CIS #2753-000004-18 related to resident to resident abuse.
Log #010326-18, CIS #2753-000005-18 related to resident to resident abuse.
Log #014489-18, CIS #2753-000007-18 related to resident to resident abuse.
Log #019572-18, CIS #2753-000009-18 related to resident to resident abuse.
Log #024939-18, CIS #2753-000012-18 related to resident to resident abuse.
Log #007214-18, CIS #2753-000002-18 related to resident to resident abuse

During the course of the inspection, the inspector(s) spoke with Interim Executive Director, Director of Care, Resident Assessment Instrument (RAI) Coordinators, Environmental Service Manager , Registered Nurses (RN), Behaviour Support Ontario Staff (BSO), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents.
Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction, reviewed relevant resident's clinical records, relevant policies and procedures, educational records and annual program evaluation.

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

During the course of this inspection, Non-Compliances were issued.
3 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	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 has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

a) This inspection was completed related to a Critical incident System (CIS) where an identified resident abused co-residents.

An identified number of CIS reports were reviewed and it stated that on specified dates an identified resident allegedly abused co-residents.

The care plan for the identified resident identified specific interventions related to responsive behaviours.

Residents’ observation on an identified date showed that the specific interventions were not in place as stated in the care plan.

A PSW said that the identified resident was independent with their activities of daily living.

A Registered Nurse (RN) said that the identified resident was independent with their activities of daily living and the interventions in the care plan were not effective. The RN acknowledged that the plan of care was not reviewed and revised when the care was not effective.

The licensee has failed to ensure the identified resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, 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 has failed to ensure that residents were protected from abuse by anyone.

The definition of "physical abuse in subsection 2(1) of the Act "physical abuse" means the use of physical force by a resident that causes physical injury to another resident."

This inspection was completed in relation to the specified critical incidents where an identified resident allegedly abused co-residents which resulted in a physical injury to co-residents.

A RPN shared that the identified resident had a history of responsive behaviours. The RPN indicated that there were triggers for their responsive behaviours.

The DOC said that the identified resident had a history of responsive behaviours. The DOC acknowledged that the altercations between residents had resulted in physical injury to co-residents and the resident should have been monitored more closely for their responsive behaviours.

The licensee has failed to ensure that identified residents were protected from abuse by resident. [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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

a) This inspection was completed in relation to a Critical incident System (CIS) related to alleged abuse by a resident towards other residents.

An identified number of CIS reports were reviewed it stated that on specified dates an identified resident allegedly abused co-residents.

Record review stated that there were a number of incidents related to resident to resident altercations that occurred in a specified place.

A PSW said that the identified resident was independent with activities of daily living, however, they had responsive behaviours.

A Registered Practical Nurse (RPN) shared that the identified resident had exhibited responsive behaviours towards other residents and most of the time the behaviour occurred in a specified place.

A Registered Nurse (RN) said that the identified interventions in the care plan were not effective.

A BSO RPN shared that when there was less supervision or when the identified resident was in the specified area unsupervised, there was more chance of a responsive behaviours. A BSO RPN acknowledged that the specified place was an issue for the resident and that other interventions had not been tried.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations between resident and other co-residents by identifying and implementing interventions.

b) This inspection was completed in relation to the review of a number of specific critical incidents where an identified resident allegedly abused co-residents which resulted in a physical injury to co-residents.

A PSW stated that they supervised the identified resident and there were interventions in place to prevent responsive behaviours.

A RPN shared that the identified resident had a history of responsive behaviours. The RPN indicated that there were triggers for their responsive behaviours.

The DOC said that the identified resident had a history of responsive behaviours. The DOC acknowledged that the altercations between residents had resulted in physical injury to co-residents and the resident should have been monitored more closely for their responsive behaviours.

Review of care plan identified specific interventions related to responsive behaviours.

In reviewing all three CIS reports it was noted that all three incidents occurred in a specified area and staff responded after the incident had happened. Steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions, to be implemented voluntarily.

Issued on this 28th day of November, 2018

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

Original report signed by the inspector.