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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 3, 2013	2013_226192_0017	L-000765-13	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 17, 21 and November 7, 2013.

During the course of the inspection, the inspector(s) spoke with the Director of Care (Acting), the Assistant Director of Care, registered staff, and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed medical records, assessments, incident reports and policy and procedure.

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

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (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 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 or care set out in the plan is no longer necessary.

A) The plan of care for resident #001, dated as reviewed September 2013 and available to staff, indicated under Urinary Elimination that the resident had occasional bowel and bladder incontinence and that a toileting routine was established. Under toileting it is identified that the resident had a regular bowel elimination pattern and required the assistance of one staff member.

Documentation review including progress notes and flow sheets indicates that in August and September 2013, resident #001 was frequently incontinent with incontinence documented on all but three occasions.

A review of the progress notes and interview confirm that resident #001 was incontinent of their bowels the majority of the time and required the assistance of up to three people to provide care, due to an exacerbation in aggressive behaviours.

B) The mood state and behaviour plan of care dated as updated September 2013 and currently available to staff, does not address the residents increased anxiety related to the provision of assistance with care and specifically perineal care or undressing.

The medical record for the period between July and October 2013 was reviewed and identified 30 documented incidents of physical aggression during the provision of care including perineal care and dressing.

C) Interventions that were documented as having been effective were not included in the plan of care for the benefit of all staff caring for resident #001.
e.g. "Staff used distraction and redirection to calm the resident"; "Analgesic provided 30 minutes prior to care resident was more compliant"; "two staff for all care"; "One staff holding resident's hands while talking to resident while another staff completed care".

D) The plan of care for resident #001 related to Activities of Daily Living (ADL) assistance, dated as reviewed September 2013 and currently available for staff, indicated that the resident required intermittent encouragement, needed assistance with opening cartons, cutting meat but does not require further assistance.

Record review indicated that since August 2013 resident #001 required the assistance of staff to eat their meal and on specified dates they required total feeding.

A nutrition note indicated that the resident required extensive assistance and the diet was changed to a mechanically altered diet. The plan of care available to staff at the time of this inspection had not been updated to include this change in required assistance.

Resident #001 exhibited changes in condition over the review period of July to October, 2013. There was no evidence of reassessment of the resident's bowel and bladder continence or responsive behaviours and the plan of care was not reviewed and revised to address these changes in condition and interventions that were identified to have been effective. [s. 6. (10) (b)]

2. The licensee failed to ensure that the resident was 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 had not been effective.

Documentation review and interview confirm that resident #001 was demonstrating ongoing responsive behaviours that put the resident and others at risk. Staff completed ongoing Dementia Observation Scale (DOS) charting between July and October 2013 related to the behaviours exhibited by resident #001. In September 2013 Confusion Assessment Method (CAM) was completed for resident #001.

Review of the plan of care related to Mood State/Behaviours, dated as revised September 2013 and available for staff use up to the time of the resident's transfer from the home area in 2013, identified interventions that included: keep environmental noises to minimum, provide a consistent care giver, offer simple choices, provide diversional activities.

In spite of these interventions the resident demonstrated aggressive behaviours directed at staff and residents.

Resident #001 continued to demonstrate behaviours almost daily until a specified date when a resident was injured and resident #001 was transferred from the Neighborhood. The plan of care was ineffective in maintaining the safety of resident

#001 and others.

Documentation related to resident #001, completed by the Behaviour Supports Ontario (BSO) staff was reviewed. There is no indication of analysis of information gathered, or alternative interventions initiated related to information gathered.

There is no documented evidence of review and revision of the plan of care related to interventions that were not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 ensuring that residents are 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 had not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

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1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or other wise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

A) The homes policy titled Fall Prevention and Management [LTC] dated February 2013 states under Post-Fall Management:

4. The Registered Team Member will document the fall using the Falls Incident Report Form located on GoldCare.

6. The Resident will be assessed each shift for 24 hours after the fall by the Registered Team Member who is on the Neighbourhood. A progress note will be completed for three shifts.

A) In September 2013 documentation identified that resident #001 attempted to sit down and sat on the floor instead of the chair. Interview confirms that this incident would constitute a fall by the home's definition of a fall and that no Fall Incident Report Form was completed. Interview also confirms that completion of the Fall Incident Report Form would constitute the post fall assessment.

Documentation was not completed on the progress notes for three shifts following the September 2013 fall.

B) In August 2013 resident #001 sustained a fall for which a Fall Incident Report Form was completed however the fall was not documented in the progress notes as having occurred.

Documentation was not completed on the progress notes for three consecutive shifts following the August 2013 fall.

C) In July 2013 resident #001 sustained a fall. Progress notes for three consecutive shifts following the fall were not completed. [s. 8. (1) (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 ensuring that required plans, policy, protocol, procedure, strategy or systems are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A) Documentation review identified that in September 2013 a Registered Practical Nurse documented that two weeks prior an incident was witnessed that involved resident #001. A person visiting the home was observed pushing the resident up against a window and stating to the resident that they are not to touch other residents. The person involved in this incident raised their fists toward the resident. The resident became agitated and staff intervened to separate the person and the resident.

Interview confirms that this witnessed incident of abuse of a resident by anyone was not immediately reported to the Director.

B) Documentation review identified that in September 2013 resident #001 was observed to have became agitated and struck a visitor. The visitor responded to resident #001 by saying "if you hit me again, I will knock you to the floor".

No incident report was submitted notifying the Director of this incident of abuse. [s. 24. (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 ensuring that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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

Issued on this 4th day of December, 2013

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

Debora Saville (192)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2013_226192_0017
Log No. / Registre no:	L-000765-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 3, 2013
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HEATHER CAUWENBERGHE

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall develop, submit and implement a plan to ensure that residents are reassessed when changes in behaviour, continence and eating are evident and that the plan of care is reviewed and revised when a resident's care needs change.

The plan shall be submitted electronically to Long Term Care Homes Inspector Debora Saville of the Ministry of Health and Long Term Care, London Service Area Office at debora.saville@ontario.ca by December 17, 2013.

Grounds / Motifs :

1. Previously issued January 18, 2013 as WN

The licensee failed 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, the resident's care needs change or care set out in the plan is no longer necessary.

The plan of care for resident #001, dated as reviewed September 2013 and available to staff, indicated that the resident had occasional bowel and bladder incontinence and that a toileting routine was established. Under toileting it is identified that the resident had a regular bowel elimination pattern and required the assistance of one staff member.

Documentation review including progress notes and flow sheet indicates that resident #001 was frequently incontinent with incontinence documented on all but three occasions in August and September 2013.

A review of the progress notes and interview confirm that resident #001 was incontinent of their bowels the majority of the time and required the assistance of up to three people to provide care, due to an exacerbation in aggressive behaviours.

The mood state and behaviour plan of care dated as updated September 2013 and currently available for staff access, does not address the residents increased anxiety related to the provision of assistance with care and specifically perineal care or undressing.

The medical record for the period between July 2013 and October 2013 was reviewed and identified 30 documented incidents of physical aggression during the provision of care including perineal care and dressing.

Interventions that were documented as having been effective were not included in the plan of care for the benefit of all staff caring for resident #001 e.g. Staff used distraction and redirection to calm the resident; Analgesic provided 30 minutes prior to care resident was more compliant; two staff for all care; One staff holding resident's hands while talking to resident while another staff completed care.

The plan of care for resident #001 dated as reviewed September 2013 and currently available for staff indicated that the resident required intermittent encouragement, needed assistance with opening cartons, cutting meat but does not require further assistance.

Record review indicates that resident #001 required the assistance of staff to eat his meal and on specified dates in 2013 they required total feeding.

A nutrition note indicated that the resident required extensive assistance and the diet was changed to a mechanically altered diet. The plan of care available to staff at the time of this inspection had not been updated to include this change in required assistance.

Resident #001 exhibited changes in condition over the review period of July to October 2013. The plan of care was not reviewed and revised to address these changes in condition and interventions that were identified to have been effective. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of December, 2013

Signature of Inspector / Signature de l'inspecteur : Debora Saville (192)

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

Service Area Office / Bureau régional de services : London Service Area Office