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

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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
Jul 4, 2013	2013_195166_0017	002237-12,000050,000139,000233	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

RIVERVIEW MANOR NURSING HOME
1155 WATER STREET, PETERBOROUGH, ON, K9H-3P8

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

CAROLINE TOMPKINS (166)

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): April 29, 2013

This inspection was conducted to inspect 4 critical incidents , log O-002237-12,000139-13,000050-13 and 000233-13

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, the Director of Care, the MDS RAI Coordinator, staff members of the Behavioural Support Team Ontario (BSO), Registered staff and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the clinical health records of residents, the licensee's policies related to the Managing of Responsive Behaviours, Reporting Incidents of Abuse, Training and Orientation.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

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1. Log O-000139-13
Critical incident # 2722-000012-13 was submitted reporting an incident of resident to resident physical abuse.
Clinical documentation indicated prior to the reported incident, Resident #4 was displaying anger and physically aggressive behaviour.
The plan of care directs staff to manage the physically aggressive and angry behaviour demonstrated by Resident #4 by:
-one staff only to direct Resident #4, provide resident with undivided attention
-allow resident time to express feelings and concerns each shift in order to decrease the incidents of this behaviour
- all other staff clear area of other residents
- direct Resident #4 to the end lounge and set up a movie and magazines.
The plan of care did not give clear direction to staff on how to manage the responsive behaviour of Resident #4, when the intervention of directing Resident #4 to the lounge to watch a movie was ineffective.
On an identified date, Resident #4 left the lounge and pushed resident #5 causing Resident #5 to fall and sustain an injury. [s. 6. (1) (c)]

2. Log O-000050-13
Resident #2's plan of care identifies the resident as being a high risk for elopement. The plan of care outlines interventions to minimize the elopement attempts /incidents. Resident #2's plan of care does not provide clear direction to staff on how to proceed when the resident does elope from the home, including identifying the areas where the resident is most often to be found when the resident leaves the grounds. [s. 6. (1) (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 the licensee shall ensure that the written plan of care of care sets out clear direction to staff and others who provide direct care to the residents., 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. Log O-002237-12
Clinical documentation indicated that a crisis care plan was developed to respond to resident #2's inappropriate touching of another resident. The plan of care identified possible triggers that included resident needing toileting and/or increased stimulation to reduce boredom. Interventions to manage the resident's responsive behaviours included toileting,participation in offered activities and Montessori methods for seniors. A second incident of inappropriate touching occurred involving the same resident. There was no evidence that any other behavioural triggers were identified or any other inventions were implemented to manage the resident's responsive behaviours. [s. 53. (4) (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 the licensee shall ensure that, for each resident demonstrating responsive behaviours, all behavioural triggers are identified and interventions are implemented to respond to the responsive behaviours., to be implemented voluntarily.

WN #3: 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's policy related to Caring for a Physically Aggressive /Abusive Resident CS-10.2 indicates the purpose of this policy is :
-to eliminate the risk of injury and /or physical discomfort to a resident exhibiting responsive behaviours,e.g. aggression, resistance to care and to eliminate the risk of injury and/or physical discomfort to an employee caring for such a resident.
The policy does not address procedures and interventions to assist other residents who are at risk of harm or who are harmed as a result of residents' behaviour and does not address procedures and interventions to minimize potential harmful interactions between and among residents. [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 the licensee shall ensure that procedures and interventions are developed and implemented to assist residents 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 potential harmful interactions between and among residents., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Log O-002237-12
Interview with the Director of Care and review of clinical records indicated the police were not notified of the 2 witnessed incidents of inappropriate touching involving resident #2. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Log O-002237-12
Interview with the Director of Care and review of clinical documentation indicated the results of the the abuse investigations were not reported to the Director. [s. 23. (2)]

Issued on this 4th day of July, 2013

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