Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2015	2015_360111_0007	O-001651-15	Resident Quality Inspection

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

LYNDA BROWN (111), CHANTAL LAFRENIERE (194), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 9-13 & 16-20, 2015

During the RQI inspection, 7 Critical Incidents(log #000485-14,#000532, 000994, 001272, 001481, 001625 & #001504) and 1 complaint (log# 001292)were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nursing Administrative Service Manager (NASM), Physiotherapist (PT), Resident Services Coordinator (RSC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Families, Resident Council President, Family Council Chariperson, Behavioural Support Ontario (BSO), Housekeeping, and Environmental Manager. The inspectors also conducted a tour of the home, observed meal service, medication administration, reviewed health care records, investigations by the home, family and Resident Council meeting minutes, and the home's policies on preventative maintenance, prevention of abuse and neglect, Skin assessments, and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
10 WN(s)
5 VPC(s)
1 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. 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 and free from neglect by the licensee or staff in the home.

Related to log #001735:

Under O.Reg. 79/10, s.5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical Incident Report was received on a specified date for an allegation of staff to resident neglect resulting in injury. The CIR indicated Resident #61 was found by staff with an injury to a specified area and the "investigation was initiated and continuing".

Interview of the Administrator indicated that Resident #61 was currently in hospital (unrelated). The Administrator indicated the investigation into the incident of neglect of resident care for Resident #61 determined that 3 staff were directly involved in the neglect of Resident#61 and actions were taken as a result.

Review of the home's policy "Abuse/Neglect of Residents by Staff" (HR-RA-2.2) indicated under procedure: the employee(s) alleged to have committed the abusive or neglectful act will immediately be removed from the work environment pending investigation.

Review of the homes investigation indicated:
-Staff who discovered the neglect of Resident #61 immediately reported to the charge nurse an allegation of staff to resident neglect resulting in injury and the allegation was immediately reported to the Administrator.
-The immediate actions taken by the Administrator included: providing verbal direction to the charge nurses to reassign (one of the staff members involved)to provide care to other residents and monitor care provided to Resident #61.
-The Administrator began the investigation (interviewing staff) 3 days later.
-The investigation confirmed the allegation of staff to resident neglect towards Resident #61 (resulting in injury) as the resident did not receive care according to the plan of care. The investigation indicated the neglect of care involved by 3 staff members (not one),and also indicated that one of the staff members involved in the neglect had also neglected to provide care to Resident #16 & #17 (that were not monitored to ensure care was provided).
-The investigation indicated 2/3 staff involved in the neglect had continued to work until commencement of investigation 3 days later (despite the home's policy indicating staff

are to be removed from work pending an investigation).
-The investigation indicated that actions were taken towards all 3 staff members involved in the neglect towards Resident #61 but no immediate actions were taken regarding one staff member (who neglected Resident #16 & #17 and continued to work for 2 days) and no immediate actions were taken for the second staff member who continued to work for 3 days, prior to initiation of the investigation to ensure all residents were not neglected.
-The Administrator also indicated Resident #61 was provided with emotional support by the Life Enrichment Coordinator Aide(LECA) after the incident but the Resident #61 was not seen by the LECA until five days later.
-Review of the progress notes for Resident #61 indicated there was no documentation regarding the status of the resident's injury following the neglect (for three shifts over the next two days after the incident).

-The licensee failed to ensure that when they had reasonable grounds to suspect neglect of care towards Resident #61,(and Resident#16 & #17) that appropriate actions were taken as the staff involved in the allegation of neglect continued to work (prior to the home initiating their investigation), the verbal instructions provided to the RN's in charge were not consistently implemented, and the Registered Nursing staff did not consistently document Resident#61 status as issued under LTCHA, 2007, s.19(1)(as indicated under WN#1).
-The licensee failed to ensure the plan of care related to personal hygiene and toileting was provided to Resident #61 as issued under LTCHA, 2007, s.6(7) (as indicated in WN#2).
-The licensee failed to follow their policy for Prevention of Abuse and Neglect by immediately investigating the alleged staff to resident neglect towards Resident #61 (and Resident #16 & #17) as issued under LTCHA,2007, s.23(1)(a) (as indicated in WN#3).
-The licensee failed to ensure the home's policy for Zero Tolerance of Abuse and Neglect met the requirements under the legislation related to immediately investigating any allegation, suspicion or witnessed incidents of abuse and/or neglect as issued under LTCHA, 2007, s.20(2) (as indicated in WN#8).

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care was provided to Resident#41 as specified in the plan, related to responsive behaviours.

Related to log #001481:

Review of the progress notes, Critical Incident Report and staff interviews indicated that on a specified date and time, a staff member escorted Resident #41 into the dining room for supper. The staff member then left Resident #41 to assist another resident. During this time, Resident #41 then became involved in a physical altercation with Resident #43 resulting in injury to Resident #43.

The plan of care for Resident #41 (in place at time of incident)directs staff to have 1:1 observation (while awake). The plan of care was not provided during this incident as there was no 1:1 staff member present.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to Resident #47 as specified in the plan, related to responsive behaviours.

Related to log# 001504:

A critical incident report was submitted to the Director on a specified date for an

allegation of staff to resident physical abuse incident that occurred the day before.

Review of health record, CIR and the home's investigation indicated, on a specified date, Resident #47 entered Resident #43 room and refused to leave. Staff #111 entered the room of Resident #43(to assess Resident #43 post fall) and attempted to redirect Resident #47 from the room, but the resident refused to leave. Staff #111 then attempted to physically remove Resident#47 from the room which resulted in Resident#47 falling to the floor. The home's investigation indicated 4 Staff (#110, #111, #114 and #115) were actually present during the incident. Staff #111 used a "stern, firm voice" several times when attempting to redirect Resident #47 from Resident #43 room. Staff # 110, #114 & #115 did not provide assistance to Staff #111 when Resident #47 was non-compliant and Resident #47 was not re-approached at a later time.

The plan of care for Resident #47(in place at time of incident) directs staff to "approach using a calm manner, explain to resident prior to care what you will be doing for them and when" and "if resident refuses/declines, leave and return 10 minutes later to offer care again, and have a different staff member offer care". Therefore, care set out in the plan of care was not provided as specified.

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to personal hygiene and toileting.

Related to log # 001735:

A critical Incident report was received on a specified date for an allegation of staff to resident neglect resulting in an injury. The CIR indicated that Resident #61 was found by staff with injury to a specified area as a result of neglect.

Review of the homes investigation indicated on a specified date, 2 staff reported to charge nurse and Administrator an injury to a specified area noted to Resident #61 as a result of neglect.

Interview of Staff #119, #120, #125 indicated Resident #61 required total staff assistance with personal care/hygiene/toileting. They indicated the resident also required cueing for repositioning. They indicated the resident requires one staff total assistance to complete personal hygiene twice daily, but two staff assistance with repositioning in bed and transfers due to physical limitations. They indicated the resident is to be transferred to a mobility aide during the day (after morning care), and staff are to check bed linens (when

in bed)for incontinence every shift(and as needed). They indicated staff are to assess the resident's skin each shift and report any breakdown to registered staff. Interview of Staff #133 indicated the resident requires two staff assistance with repositioning, personal care & changing of bed linens during the night due to physical limitations.. Interview of Staff #132 indicated that Resident #61 only required one staff assistance during the night and Resident#61 was able to "reposition self".

The plan of care for Resident #61 (in place at time of incident) indicated the resident required total staff assistance, staff to provide "bed care" with each "toileting experience" and to cue the resident for repositioning in bed. Required one staff assistance with personal hygiene/toileting and required two staff assistance for bed mobility and transfers. The plan of care indicated staff were to monitor skin daily during morning a bedtime care and report any signs of breakdown to registered staff for follow up. Therefore, the plan of care was not provided as the resident did not receive personal hygiene and toileting as indicated in the plan.

4. The licensee has failed to ensure that the care set out in the plan of care was provided to Resident#17 as specified in the plan, related to skin integrity.

On a specified date, Inspector #570 interviewed and observed Resident #17, and noted that the resident had sustained injury to specified areas. The inspector reviewed the "shift to shift report" and Resident #17's progress notes for the two week period prior to and including that date, and there was no documentation related to the injuries noted on Resident #17.

Review of Resident #17's current plan of care related to skin integrity directs staff to assess Resident #17’s skin condition during morning and evening care and report to registered staff any areas of concern for follow up.

On a specified date, interview with Staff #128 (who provided personal care to Resident #17) during the same time period indicated no awareness of any injuries to Resident #17.

Interview of the DOC indicated the expectation of the home is that PSW staff assess skin condition during care at every morning and evening shift and report any concerns to registered staff for follow up. The DOC indicated the injuries to Resident #17’s should have been noticed and reported to Registered Nursing staff for follow up as required in the plan of care. Therefore, the plan of care was not provided to Resident #17 related to

skin integrity.

5. The licensee has failed to ensure that the plan of care was provided to Resident #60 as specified in the plan related to responsive behaviours.

Related to log# 000994:

A critical Incident report was received on a specified date for a resident to resident physical abuse incident that occurred the day before. The CIR indicated Resident #60 was witnessed by a PSW in a physical altercation towards Resident #57 resulting in Resident #57 sustaining an injury. The CIR indicated Resident #60 had previously exhibited physically aggressive responsive behaviours towards other residents (but did not result in any injuries).

Review of the progress notes for Resident #60 (for a three month period)indicated the resident demonstrated 16 incidents of verbally and/or physically aggressive, and threatening responsive behaviours(both provoked and unprovoked). The incidents occurred towards other residents (Resident #28, #41(x3), #47, #49, #53(x2), #57(x3), #62(x2), two unidentified residents) and a visitor. Resident #62 expressed "fear" of Resident #60. Resident #41, #53 & #57 sustained injury as a result of the physical aggression by Resident #60. The incidents occurred in common areas. Interventions included redirection, every 15 minute checks and 1:1 monitoring (after the 9th and 12th incident while awake for 7 days). Two incidents occurred while the resident was on 1:1 monitoring (but 1:1 staff was not present).

The plan of care(in place during that time period) for Resident #60 related to responsive behaviours indicated the resident demonstrated "aggressive" and "physically abusive" behaviour towards other residents [Resident #53, #57 & #41]. Interventions included:
- every 15 min checks (which was started, discontinued and restarted)
- monitored on every 15 min checks and "checked in on by the 1:1 PSW". The Supportive Measures PSW (SM-PSW)will be responsible for monitoring the resident and another resident, "completion of the every 15 minute checks for those possible during their shift. Both residents are on Q15 minute checks but staff are not required to sit with them during their whole shift. Should either resident have an escalation of behaviour, then the SM-PSW should remain with that
resident until has settled". The SM-PSW will complete care, every 15min checks, set up activities (as per Day in the life) for Resident #60 and three other residents.
- 1:1 observation (started, discontinued, and restarted again) and from 2300hrs-0700hrs

there will be a staff completing the every 15min checks for Resident #60 (and three other residents).

Interview of BSO staff and review of staff scheduling records indicated that 1:3 monitoring was in place during most of the incidents of verbal and physical aggression towards other residents, some which resulted in injury. BSO staff indicated that 1:3 refers to one PSW staff member having to monitor three residents at the same time with responsive behaviours, but if one of those residents has responsive behaviours, then that staff member is unable to monitor the other two residents. Interview of BSO staff and review of staff scheduling records also indicated the 1:1 monitoring of Resident #60 was in place during one of the incidents that occurred.

Therefore, the care set out in the plan of care for Resident #60 related to monitoring, was not provided as specified in the plan, as the resident was not receiving 1:1 monitoring (during the specified dates), was receiving 1:3 monitoring, and not receiving every 15 minute checks (during the specified dates). [s. 6.(7)]

6. The licensee has failed to ensure that the plan of care for Resident #44 was reviewed and revised at least every six months, and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary related to responsive behaviours.

Related Log #000485:

A critical incident report was received on a specified date for a missing resident (less than 3 hours). The CIR indicated the incident occurred 6 days earlier at a specified time. The CIR indicated the home was informed by an outside caller from another Long-Term Care home that Resident #44 was in their home after being dropped off by a visitor. The staff immediately returned Resident #44 to the home and no injuries noted. The resident had a wander guard bracelet applied.

Review of the progress notes (for a 4 month period) for Resident #44 indicated the resident had 7 incidents of exit seeking behaviours prior to the elopement incident. BSO team member noted after completion of a two week DOS charting (during the same time period)"No responsive behaviors or exit seeking statements". On the day of elopement, the front door was left un-alarmed.

Review of RAI-MDS assessments (during the same period) indicated Resident #44 "is no

longer wandering". The RAP summary indicated that the resident requires guidance from staff as "will often make poor decisions such as exit seeking".

Interview with BSO (#121) indicated that the plan of care for Resident #44 should have been updated to identify the exit seeking behaviours with appropriate interventions such as wander guard use prior to the elopement incident.

Review of the plan of care(in place at time of elopement incident) for Resident #44, identified the resident demonstrated "wandering" responsive behaviours and the need to monitor the resident. Interventions included:
-allow to pace in safe, supervised areas either inside or outside;
-determine if there is any reason for the wandering (ie. need to go to the bathroom);
-distract the resident with activities or conversation if starting to pace;
-every 15 min checks (were discontinued during the same time period).

The plan of care was not revised to identify the ongoing "exit-seeking" responsive behaviours demonstrated and as identified in the RAI-MDS assessment and there were no interventions to manage this responsive behaviour. The every 15 minutes monitoring of the resident was also discontinued (despite the resident demonstrating continued "exit-seeking" responsive behaviours).(570) [s. 6. (10) (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 that the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee has failed to ensure the resident-staff communication and response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

The activation room and hairdressing room by the nursing station on North wing did not have a resident-staff communication and response system in place. Both of these areas are accessed and used by residents, staff and visitors.

The ESM indicated that both rooms were not equipped with a resident-staff communication and response system.

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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Related to log #001504:

A critical incident report was submitted to the Director on a specified date for an allegation of staff to resident physical abuse incident that occurred the day before.

The CIR, the homes investigations, interview of staff, and review of the resident's health record indicated on a specified date Staff #110 & #114 found Resident #43 on the floor in the resident's room(post fall). Resident #47 then entered Resident #43 room and refused to leave. Staff #111 entered the room of Resident #43(to assess Resident #43) and asked Resident #47 repeatedly to leave the room, but the resident refused to leave. Staff #111 then attempted to physically remove Resident#47 from the room which resulted in Resident#47 falling to the floor. Staff #110 & #114 reported to Staff #113 (in charge) an allegation of Staff #111 being verbally and physically abusive towards Resident#47.

Interview of Staff #113 (in charge) indicated no investigation was initiated. Interview of

the Administrator indicated Staff #113 should have initiated the investigation.

The allegation of staff to resident abuse was not investigated until the following day when the Administrator and DOC were made aware of the incident.

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident of staff to resident neglect, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Related to log #001735:

Interview of the Administrator indicated on a specified date and time, staff witnessed an incident of neglect resulting in injury to Resident #61 and immediately reported the neglect to the Administrator. The Administrator indicated she did not investigate or interview any staff to determine who may have been involved in the neglect (until 3 days later). The Administrator then determined after interviewing staff the incident of neglect of care for Resident #61 involved 3 staff (Staff #122, #123, #124). The Administrator indicated Staff #122 & #123 continued to work two days after the incident but Staff #122 did not provide care to Resident #61.

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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:(i) abuse of a resident by anyone,or (ii) neglect of a resident by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, within six weeks of the admission of the resident, and at least annually after that.

During stage 1 of the RQI, a family interview for Resident #35 stated "was supposed to have a care conference last year but got cancelled due to an outbreak and never got rescheduled".

Interview with Resident Services Coordinator(RSC) indicated:
-schedules all the 6-week and annual care conferences,
-all care conferences are cancelled during an outbreak,
-calls are placed to the family to reschedule when the home is in outbreak and if the family does not call back to reschedule, the annual care conference does not occur.
-confirmed that Resident #35 did not have an annual care conference in 2014.

Review of the Annual Care conferences completed in 2014 was provided by the RSC and indicated 16 additional residents did not have an annual care conference (due to outbreaks in the home) and were not rescheduled in 2014: Resident #13, #25, #31,#34, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58 & #59.

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 a care conferences of the interdisciplinary team is held annually for each resident to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker, if any, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1.Related to Log #000485:

The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of the incident of "a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition".

A Critical Incident Report was submitted to the Director on a specified date for a missing resident less than 3 hours, with no injury. The CIR indicated six days earlier, Resident #44 was identified as missing after an outside caller notified the home that one of their resident's (identified as Resident #44 by arm band) was at another LTC home.

The Administrator confirmed that the Director was not notified within one business day after the occurrence of the incident.

2. Related to Log #000485:

The licensee has failed to ensure that the Director was notified no later than one business day after an incident "that caused an injury to a resident and resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital".

A Critical Incident Report was submitted to the Director on a specified date for a fall with injury resulting in transfer to hospital.Review of progress notes indicated 9 days earlier, Resident #44 was found on the floor complaining of pain to a specified area. The resident was transferred to hospital with an injury and then passed away 5 days later.

The Administrator confirmed that the Director was not notified within one business day after Resident #44 fell and was transferred to hospital and that resulted in a significant change in the resident's health condition.

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 Director is informed no later than one business day after the occurrence of the incident followed by the report for a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition, and for any injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize the risk to the resident.

The following observations were noted over a two day period related to bed rail use:
-Resident #2 had 2 quarter bed rails in the "up" position at the top of the bed with full bed rail padding wrapped around the quarter bed rails.
-Resident #13 had 2 quarter bed rails in the "up" position at the top of the bed.
-Resident #28 had 2 quarter bed rails in the "up" position at the top of the bed.
-Resident #45 had 2 quarter bed rails in the "up" position in the middle of the bed with 3/4 bed rail padding wrapped around the quarter bed rails.

Interview of the DOC indicated that the home does not consider "quarter bed rails" as a restraint or Personal Assistive Safety Device (PASD) but the bed rail in use should be indicated in the care plan, identifying the type of bed rails used, any padding used on bed rails, and why the bed rails/padding are used. The DOC indicated the home has assessment tools for use of bed rails but there were no assessments completed for the identified residents.

Review of care plan for Resident #2 had no indication of which type of bed rail was to be used or any indication that padding was to be applied to the bed rails.

Review of care plan for Resident #13 indicated ensure two "half side rails" are up when in bed but 2 quarter rails were in place.

Review of care plan for Resident #28 indicated "staff to ensure that two rails" are up while in bed and encourage to ring for assistance. There was no indication of which type of bed rails were to be used.

Review of care plan for Resident #45 indicated "ensure two quarter rails are up when in bed. There was no indication why the bed rails were used, why the quarter bed rails were placed in the middle of the bed, and no indication of the use of padding on the bed rails that were in place.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On March 9, 2015, the following were observed by the inspector:
-resident room door(s): O107,O108, O104,O103, O101,O206, L214, L207,L 208,L 206 and L204 and activity room door (Lakefield wing) were noted to be damaged with gouges and chipped areas. The damaged doors had exposed porous material which can be difficult to clean posing an infection control concern as well as potential for skin tears on the chipped areas on the doors.
-a number of lights in the home were not working:2 ceiling light panels in hall of the Kawartha and Otonabee wing, leaving some areas shadowed. Activity Room on Otanabee had 1 of the 2 ceiling lights not working. Activity Room on LakeField Wing had 2 of the 4 ceiling lights not working. Main Dining room had 16 florescent bulbs not working in the ceiling. All lighting deficiencies identified by the inspector were reported to the ESM and are now working.
-Resident #13 reported that the window (in the shared room) was open and could not be latched.

The areas of disrepair identified below in the "list of duties" were observed by the inspector and were noted to remain in disrepair:

A "list of duties" for Maintenance (dated Feb 13, 2015) indicated that the following maintenance concerns had been addressed by the Maintenance Manager (and signed off by ESM as being completed):
-Room O106-D (by washroom): needs some areas of the wall patched and touched up with paint,
-Room O109: some areas over bed need patched and repainted,
-Room P107: Overbed light has blue cord pulled out needs fixed.

Interview of the ESM indicated they were aware of the damaged doors and "it was being addressed in the capital plan". The Maintenance Manager stated "he was aware of the lights in Dining room" and "changed the ones that needed to be changed". The ESM also stated that he was "continuously replacing lights in the home".

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:
(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents,

Review of the home's policy "Zero tolerance of abuse and Neglect of Residents" (AM-6.9) indicates "investigate every allegation of abuse and neglect in accordance with the complaint investigation policy". This policy does not contain procedures for "investigating and responding" or who is to complete the investigation, and redirects to another policy.

Review of the home's policy of Complaints "Investigation Procedures" (AM-6.3) indicates under purpose:
-to ensure that all complaints and allegations are thoroughly investigated "in a timely manner" and that "each allegation or complaint shall be investigated by the Administrator or designate according to the complaints procedure".This policy does not contain procedures for "investigating and responding" either but again redirects to "complaints policy".

WN #10: 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.The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm, or risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director.

Related to log #001491:

Interview of the DOC indicated a Critical Incident Report was submitted on a specified date for resident to resident physical abuse between Resident #41 and #43 that occurred. The incident resulted in injury to Resident #43 and the incident was not reported to the Director until the CIR was submitted (3 days later).

2. Related to log #001504:

A critical incident report was submitted to the Director on a specified date for an allegation of staff to resident abuse incident that occurred. The day before, Staff #110 & #114 found Resident #43 on the floor in the resident's room. Resident #47 then entered Resident #43 room. Staff #111 entered the room of Resident #43(to assess Resident #43) and asked Resident #47 repeatedly to leave the room, but the resident refused to leave. Staff #111 then attempted to physically remove Resident #47 from the room and Resident #47 fell to the floor. Staff #110 & #114 reported an allegation to Staff # 113 (in charge) that Staff #111 was verbally and physically abusive to Resident #47.

Interview of Staff #113 indicated was informed by Staff #110 immediately of an allegation of staff to resident verbal and physical abuse towards Resident #47 which resulted with Resident #47 on the floor. Staff #113 indicated that the incident was not reported to the Director.

The DOC and Administrator indicated that incidents of abuse are to be immediately reported to the Director. They indicated that a laminated list is posted describing reporting requirements and with the MOHLTC contact information and a binder indicating reportable incidents. They indicated that the direction is to contact the Administrator if unable to reach MOHLTC.

Issued on this 22nd day of April, 2015

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

Original report signed by the inspector.

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) :	LYNDA BROWN (111), CHANTAL LAFRENIERE (194), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2015_360111_0007
Log No. / Registre no:	O-001651-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 20, 2015
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	RIVERVIEW MANOR NURSING HOME 1155 WATER STREET, PETERBOROUGH, ON, K9H-3P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARY ANNE GRECO

To OMNI HEALTH CARE LIMITED PARTNERSHIP, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance with LTCHA, 2007, s. 19(1).
The licensee shall ensure the plan includes:
-review and revise the home's policy on "Zero Tolerance of Abuse and Neglect" to ensure it clearly indicates who will be responsible for completing the investigation and that the investigation is to be completed immediately.
- all nursing staff and management will review the home's revised policy relating to "Zero Tolerance of Abuse and Neglect" , including actions to be taken when a suspicion, allegation or witnessed, incident of neglect has been reported, ensuring awareness of roles and responsibility, as it relates to the same.
- a process is in place to ensure that immediate actions are taken to respond to suspicions, allegations or witnessed incidents of staff to resident neglect, including immediately investigating, and ongoing monitoring, to ensure the safety of those residents involved and any other residents who may be vulnerable, are protected from neglect of care from staff.
- specific measures in place when non-adherence to the home's policy and or legislation
is identified, and on how ongoing monitoring is to occur specifically towards PSW# 122, #123, and #124.

The plan shall be submitted in writing and emailed to LTCH Inspector-Nursing, Lynda Brown at lynda.brown2@ontario.ca on or before April 28, 2015. The plan shall identify
who will be responsible for each of the corrective actions listed and expected time from for completion.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Related to log #001735:

Under O.Reg. 79/10, s.5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical Incident Report was received on a specified date for an allegation of staff to resident neglect resulting in injury. The CIR indicated Resident #61 was found by staff with an injury to a specified area and the "investigation was initiated and continuing".

Interview of the Administrator indicated that Resident #61 was currently in hospital(unrelated). The Administrator indicated the investigation into the incident of neglect of resident care for Resident #61 determined that 3 staff were directly involved in the neglect of Resident#61 and actions were taken as a result.

Review of the home's policy "Abuse/Neglect of Residents by Staff" (HR-RA-2.2) indicated under procedure: the employee(s) alleged to have committed the abusive or neglectful act will immediately be removed from the work environment pending investigation.

Review of the homes investigation indicated:
-Staff who discovered the neglect of Resident #61 immediately reported to the charge nurse an allegation of staff to resident neglect resulting in injury and the allegation was immediately reported to the Administrator.
-The immediate actions taken by the Administrator included: providing verbal direction to the charge nurses to reassign (one of the staff members involved)to provide care to other residents and monitor care provided to Resident #61.
-The Administrator began the investigation (interviewing staff) 3 days later.
-The investigation confirmed the allegation of staff to resident neglect towards Resident #61 (resulting in injury) as the resident did not receive care according to the plan of care. The investigation indicated the neglect of care involved by 3 staff members (not one),and also indicated that one of the staff members involved in the neglect had also neglected to provide care to Resident #16 & #17

(that were not monitored to ensure care was provided).
-The investigation indicated 2/3 staff involved in the neglect had continued to work until commencement of investigation 3 days later (despite the home's policy indicating staff are to be removed from work pending an investigation).
-The investigation indicated that actions were taken towards all 3 staff members involved in the neglect towards Resident #61 but no immediate actions were taken regarding one staff member (who neglected Resident #16 & #17 and continued to work for 2 days) and no immediate actions were taken for the second staff member who continued to work for 3 days, prior to initiation of the investigation to ensure all residents were not neglected.
-The Administrator also indicated Resident #61 was provided with emotional support by the Life Enrichment Coordinator Aide(LECA) after the incident but the Resident #61 was not seen by the LECA until five days later.
-Review of the progress notes for Resident #61 indicated there was no documentation regarding the status of the resident's injury following the neglect (for three shifts over the next two days after the incident).

-The licensee failed to ensure that when they had reasonable grounds to suspect neglect of care towards Resident #61,(and Resident#16 & #17) that appropriate actions were taken as the staff involved in the allegation of neglect continued to work (prior to the home initiating their investigation), the verbal instructions provided to the RN's in charge were not consistently implemented, and the Registered Nursing staff did not consistently document Resident#61 status as issued under LTCHA, 2007, s.19(1)(as indicated under WN#1).
-The licensee failed to ensure the plan of care related to personal hygiene and toileting was provided to Resident #61 as issued under LTCHA, 2007, s.6(7) (as indicated in WN#2).
-The licensee failed to follow their policy for Prevention of Abuse and Neglect by immediately investigating the alleged staff to resident neglect towards Resident #61 (and Resident #16 & #17) as issued under LTCHA,2007, s.23(1)(a) (as indicated in WN#3).
-The licensee failed to ensure the home's policy for Zero Tolerance of Abuse and Neglect met the requirements under the legislation related to immediately investigating any allegation, suspicion or witnessed incidents of abuse and/or neglect as issued under LTCHA, 2007, s.20(2) (as indicated in WN#8). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

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.

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 20th day of April, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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