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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Aug 21, 2015	2015_328571_0005	O-002159-15, 001954-15, 002587-15, 002016-15, 002403-15, 002440-15	Follow up

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 17, 18 and 19, 2015.

Log #O-002587-15, O-002440-15, O-002403-15, O-001954- 15, O-002016-15 were inspected concurrently with Follow-up Log # O-002159-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Registered Nurse(RN), Registered Practical Nurse(RPN), and Personal Support Workers (PSW), Residents, and Family Members. In addition the following Policies were reviewed: Zero Tolerance of Abuse and Neglect of Residence; Reporting Incidents of Abuse; Abuse Reporting Guideline Table; Disclosure of Critical Incident; Investigation Procedures. The following were also reviewed: Education records and content of education sessions; clinical records for residents involved; and investigation notes for the reported incidents of alleged abuse and the conclusion of the investigations.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	WN	2015_360111_0007	571
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_360111_0007	571

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. 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. The licensee has failed to ensure that the results of an abuse investigation and actions taken were reported to the Director.

Related to Log #O-002440-15:
On a specified date, a Critical Incident(CI) regarding an alleged incident of physical abuse was submitted to the Director. The CI indicated that Resident #2 alleged that Staff #106 had physically abused the resident and an abuse investigation was in process.

The home initiated an investigation on a specified date. A review of investigation notes indicated that the Home concluded their investigation and action was taken.

In an interview, the Administrator indicated that the outcome of the investigation and actions taken were not reported to the Director.

Related to Log #O-001954-15:
On a specified date, a Critical Incident regarding an alleged incident of verbal abuse was submitted to the Director. The CI indicated that Resident #5 alleged that Staff # 105 had verbally abused him/her.

On a specified date, a Critical Incident regarding an alleged incident of verbal abuse was also submitted to the Director. Resident #5 alleged that Staff #104 had verbally abused him/her.

The Home initiated abuse investigations immediately. A review of the investigation notes for both incidents indicated that an investigation had been completed and action taken.

In an interview, the Administrator indicated that the results of both investigations and their outcome had not been reported to the Director.

As of August 17, 2015, the Licensee has not amended any of the fore mentioned Critical Incidents to include the outcomes of the investigations and the actions taken. [s. 23. (2)]

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 with the requirement to report the results of every investigation undertaken under clause (1)(a), and every action taken under clause (1)(b). 2007, c.8,s.23(2), to be implemented voluntarily.

Issued on this 21st day of August, 2015

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

Original report signed by the inspector.