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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 2016	2016_280541_0031	017352-16, 018379-16, 027261-16, 027506-16, 029469-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

AMBER LAM (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 27, 28, 31 and November 1, 2016

The following logs were completed during this inspection:
Log #018379-16 Resident fall with fracture and transfer to hospital
Log #017352-16 an allegation of resident to resident abuse
Log #027506-16 an allegation of resident to resident abuse
Log #027261-16 an allegation of staff to resident abuse
Log #029469-16 an allegation of resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a housekeeper, an Activity Aide and Residents. In addition the inspector reviewed resident health care records, observed resident to resident interactions and reviewed relevant policies.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 the abuse or neglect investigation were reported to the Director.

Re: #027261-16

A critical incident report was submitted by the home's Administrator on a specified date regarding an alleged staff to resident abuse. It was alleged that PSW #100 provided improper care to resident #002 on a specified date 4 days earlier.

The home indicated on the critical incident report (CIR) that the "investigation is ongoing at this time and the MOHTLC will be updated on a specified date". Under the heading for long term actions to correct this situation and prevent recurrence the CIR indicated "We will update the Ministry of Health –Long Term Care".

The CIR was reviewed by the Central Intake, Assessment and Triage Team (CIATT) who requested the home amend the CIR and include the outcome of their investigation and long term plan of action to prevent recurrence. The CIR was not amended and no updates were provided to the MOHLTC in relation to this critical incident.

During an interview with the home's Administrator she acknowledged being behind in updating the home's Critical Incident Reports. [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 to ensure that the results of all abuse or neglect investigations are reported to the Director, to be implemented voluntarily.

WN #2: 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Re: Log #027261-16

As per O. Reg 79/10 s. 2(1) sexual abuse means (b) Any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date and time a CIR was submitted for an alleged resident to resident sexual abuse that had occurred the day prior. Resident #003 was witnessed inappropriately touching resident #004's. Resident #004 was sleeping and was not aware of the interaction.

Upon review of the home's documentation into the incident, it was noted the RPN on duty at the time had contacted the home's on-call manager to inform her of the incident. On November 1, 2016 Inspector #541 interviewed the home's Assistant Director of Care (ADOC) regarding the late reporting and the ADOC confirmed the on-call manager was notified however she failed to report the incident to the MOHLTC upon receiving it and informed the home the following day. The ADOC stated during the interview the expectation would have been for the on-call manager to contact the MOHLTC via the after-hours pager.

Policy #AM-6.7 titled Reporting Incidents of Abuse was provided to Inspector #541 as part of the home's policy that promotes zero tolerance of abuse and neglect of residents. Page 3 of the policy states the following re: reporting of alleged abuse:
- Immediate reporting of critical incidents to the Ministry of Health shall occur as follows:
o After hours and Statutory Holidays by telephone to the After Hours pager. [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 that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #3: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Re: Log #029469-16

A critical incident report was submitted by the home's Administrator on a specified date regarding an alleged staff to resident abuse. It was alleged that PSW #100 provided improper care to resident #002 four days earlier.

As per O. Reg 79/10 s. 2(1) emotional abuse is any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

During the inspection, Inspector #541 reviewed the homes investigation into the incident

which included two written statements by PSW #101 who witnessed the incident. The home's documentation indicated the following:
PSW #100 and PSW #101 were in resident #002's room providing care to resident #002 who was becoming verbally upset and yelling. It was alleged PSW #101 took a pillow and put it over resident #002's face to which resident #002 stated "get that off of me" and PSW #101 responded "well stop yelling then" and removed the pillow.

Inspector #541 interviewed PSW #101 who witnessed the incident and confirmed the above noted information. PSW #101 further stated during the interview that she believes PSW #100 thought this action was funny.

During an interview with PSW #101 she stated she did not immediately report the incident as she was unsure at the time if it was something that had to be reported. PSW #101 informed RPN #102 about the incident on a specified date who then immediately reported the incident to the home's management. The incident was immediately reported to the MOHLTC when the licensee became aware of it.

Inspector #541 requested the home's policy that promotes zero tolerance of abuse and neglect of residents and was provided with policy #AM-6.9 titled Zero Tolerance of Abuse and Neglect of Residents.

Page 3 of policy #AM-6.9 states "A person who has reasonable grounds to suspect that any of the following has occurred or may occur is required by the Long Term Care Homes Act to immediately report the suspicion and information upon which it is based to the Director, Home's Administrator or manager on call".

The licensee failed to ensure their policy to promote zero tolerance was complied with as PSW #101 did not report an allegation of staff to resident abuse until 5 days after the incident was witnessed. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions: ii. the long-term actions planned to correct the situation and prevent recurrence.

Re: Log #027261-16

A critical incident report was submitted by the home's Administrator on a specified date regarding an alleged staff to resident abuse. It was alleged that PSW #100 provided improper care to resident #002 four days earlier.

Under the heading for long term actions to correct this situation and prevent recurrence the Critical Incident Report (CIR) indicates "We will update the Ministry of Health –Long Term Care".

The CIR was reviewed by the Central Intake, Assessment and Triage Team (CIATT) who requested the home amend the CIR and include the long term plan of action to prevent recurrence. The CIR was not amended and no updates were provided to the MOHLTC in relation to this critical incident.

During an interview with the home's Administrator she acknowledged being behind in updating the home's Critical Incident Reports. [s. 104. (1) 4.]

Issued on this 10th day of November, 2016

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

Original report signed by the inspector.