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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2017	2017_598570_0014	007620-17	Resident Quality Inspection

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

SAMI JAROUR (570), CAROLINE TOMPKINS (166), JENNIFER BATTEN (672)

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): May 8 - 11, 2017.

The following logs were inspected during the Resident Quality Inspection (RQI):

Log #003452-17 – Critical Incident Report related to an alleged staff to resident verbal/emotional abuse; and

Log #004191-17– Critical Incident Report related to improper care of a resident by staff.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Service Coordinator (RSC), Registered Dietitian (RD), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Life Enrichment Aide (LEA), Residents, Families, Residents' Council President, and Family Council President.

During the course of this inspection, the inspector(s) also toured the home, reviewed clinical health records, observed resident to resident interactions, staff to resident interactions, observed medication administration, reviewed investigation notes, family and resident council minutes, and applicable policies.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 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. 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 the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with

Related to Log #004191-17

The licensee's policy Zero Tolerance of Abuse and neglect of Residents, policy #AM-6.9 directs that:
5. In cases where a staff member witnesses/suspected hears about an act of abuse or neglect, the first course of action shall be to ensure that the resident is taken to a safe and secure place. Once the resident is physically safe, the following steps shall be taken:
-Report incident to direct manager, Director of Care or Administrator;
It is the responsibility of every OMNI staff member to report any suspected or witnessed neglect or abuse of a resident as indicated in the policy.
It is the responsibility of the Registered Staff to initiate the Mandatory Report check list upon learning of an alleged, suspected actual incident

On a specified date and time, an after hours report was submitted to the MOHLTC to report an alleged incident of improper care to resident #007.

On same specified date, Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of improper care to resident #007 which occurred two days prior to notifying the MOHLTC; Also, the incident was reported to the licensee by the resident's Substitute Decision maker (SDM) one day prior to notifying the MOHLTC.

Review of the licensee's investigation and the written witness report indicated that PSW #107 reported the incident to the charge nurse on the same day the incident occurred.

There is no evidence that the licensee was made aware of the incident by the charge nurse, as per the direction in the abuse policy until it was reported to the licensee by resident #007's SDM on a specified date, one day after the incident occurred. [s. 20. (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 to ensure that all staff comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to immediately reporting all incidents of alleged and or suspected incidence of abuse and neglect of a resident, 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;
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
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.

Related to log #003452-17

On a specified date, Critical Incident Report (CIR) was submitted to the Director, reporting an incident of an alleged staff to resident verbal abuse that occurred on a specified date two days prior to submitting the CIR.

Review of the CIR documentation, the licensee's investigation notes and inspector #166's interview with co-resident #024 who witnessed the incident, indicated, on a specified date and time, resident #006 rang the call bell for assistance. PSW #103, answered the call, raised his/her voice and responded to resident #006, what do you want, I can't understand you. As per CIR notes, on the same date of the incident, the incident was reported by co-resident #024 who overheard the incident and witnessed PSW #103 entering and leaving the room.

On May 10, 2017, 0930 hours, interview with co-resident #024, indicated PSW #103, after slamming a piece of furniture, left the room and did not provide assistance to resident #006.

The Director was notified of the incident on a specified date, two days after the incident occurred. [s. 24. (1)]

2. 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;
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Related to log #004191-17

On a specified date and time, an after hours report was submitted to the MOHLTC to report an alleged incident of improper care to resident #007.

On same specified date, Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of improper care to resident #007 which occurred two days prior to notifying the MOHLTC; Also, the incident was reported to the licensee by the resident's Substitute Decision maker (SDM) one day prior to notifying the MOHLTC.

Review of the licensee's investigation and the written witness report indicated that PSW

#107 reported the incident to the charge nurse on the same day the incident occurred.

The Director was not notified of the incident of improper care to resident #007 until two days after the incident occurred and one day after the incident was reported to the licensee by the resident's SDM. [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 to ensure that all incidents of alleged and or suspected abuse or neglect are immediately reported to the Director, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #014 was admitted to the home on a specified date with multiple medical diagnosis including cognitive decline.

Resident #014 has a bed system with bilateral quarter rails, halfway down the bed, and the plan of care states, under the bed mobility section, that staff are to provide resident #014 with extensive assistance with bed mobility by guiding hands to the bed rails to assist in repositioning and to come to a sitting or laying position. The bed side rails are also mentioned under the safety section of the plan of care, which states the side rails are used to assist resident #014 with bed mobility.

Inspector #672 interviewed PSWs #108, #113, and #114 in regards to resident #014, regarding resident #014's bed mobility and usage of bed rails. All three PSWs stated that resident #014 was no longer capable of following instructions, and was no longer able to complete tasks related to activities of daily living, even if the tasks were broken down into short, clear instructions, due to cognitive decline. They went on to state that resident #014 could no longer get out of bed without assistance and could not assist in bed mobility by holding onto the bed rails. PSW #108, #113, and #114 all stated that they engaged the bed rails for resident #014 when in bed for safety concerns, but that none of them use the bed rails for the purpose documented in resident #014's plan of care, which is bed mobility and repositioning.

The plan of care for resident #014 does not reflect the current health status nor the care needs for the resident. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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. (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.

related to log 003452-17

On a specified date, Critical Incident Report (CIR) was submitted to the Director, reporting an incident of an alleged staff to resident verbal abuse that occurred on a specified date two days prior to submitting the CIR.

The Director was notified of the incident on a specified date, two days after the incident occurred.

On May 9, 2017, interview with Director of Care, indicated the results of the abuse or neglect investigation were inconclusive and that the outcome of the investigation was not reported to the Director. [s. 23. (2)]

WN #5: 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:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. related to log #004191-17

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident,

On a specified date and time, an after hours report was submitted to the MOHLTC to report an alleged incident of improper care to resident #007.

On same specified date, Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of improper care to resident #007 which occurred two days prior to notifying the MOHLTC; Also, the incident was reported to the licensee by the resident's Substitute Decision maker (SDM) one day prior to notifying the MOHLTC.

Review of Critical Incident Report and the amended report on a specified date, does not identify names of any staff members or other persons who were present at or discovered the incident. [s. 104. (1) 2.]

Issued on this 29th day of May, 2017

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

Original report signed by the inspector.