Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 15, 2020 | 2020_640601_0015 | 004381-20, 011554-20, 012244-20, 013313-20, 014055-20 | Complaint |

### Licensee/Titulaire de permis

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

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

KARYN WOOD (601)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): July 27, 28, 29, 30, August 10, 11, 12, 13, 18, and 19, 2020.**

**The following intakes were completed in this Complaint Inspection:**

**A log related to a fall that resulted in a change in condition and care concerns.**

**Two logs related to the same incident of a fall that resulted in a significant change in condition and care concerns.**

**Two logs related to the same allegations of staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Acting RAI-MDS Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), and a resident and complainants.**

**The inspector also reviewed resident health care records, observed the delivery of resident care and services, including staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Nutrition and Hydration**
**Pain**
**Prevention of Abuse, Neglect and Retaliation**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 when a person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or risk of harm to a resident, and the information upon which it was based was immediately reported to the Director.

A complaint was received by the Director on a specified date related allegations of staff to resident abuse. A Critical Incident System Report (CIS) was submitted to the Director on a specified date involving RN #108 and resident #005. Resident #005 reported the allegations of abuse on a specified date and the Director of Care (DOC) submitted the allegations of abuse to the Director, on the following day.

During an interview, the DOC indicated to Inspector 601 that they were made aware of the allegations of staff to resident abuse involving RN #108 and resident #005 on a specified date, and they should have immediately notified the Director when the resident made the allegations of staff to resident abuse.

The licensee failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or risk of harm to a resident, and the information upon which it was based was immediately reported to the Director. [s. 24. (1)]

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**Issued on this 16th day of September, 2020**

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

**Original report signed by the inspector.**