Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 7, 2023	
Inspection Number: 2023-1218-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn	
Long Term Care Home and City: Riverview Manor Nursing Home, Peterborough	
Lead Inspector Lynda Brown (111)	**Inspector Digital Signature** Lynda Brown Digitally signed by Lynda Brown Date: 2023.06.13 16:56:36 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 9, 10, 2023

The following intake(s) were inspected:

- Intake: #00021006 - Follow-up related to Compliance Order #001 for FLTCA, 2021 - s. 25 (1).
- Intake: #00084454 - Critical Incident related to a witnessed resident to resident abuse.
- Intake: #00086778 - Critical Incident related to an outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1218-0001 related to FLTCA, 2021, s. 25 (1) inspected by Lynda Brown (111)

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that a witnessed incident of resident to resident abuse was immediately investigated.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director for a witnessed resident to resident abuse incident that resulted in one resident sustaining an injury.

The home's policy indicated the home was to investigate all allegations in a timely manner by collecting relevant documentation, identify and make note of staff who were working when the incident occurred or may have witnessed the incident and then establish the order for interviewing of staff and list of questions to be asked. There was no documented evidence of an investigation completed. The Administrator confirmed there was no documented investigation into the incident.

Failing to complete an immediate investigation into a witnessed resident to resident abuse incident resulted in inaccurate identification of staff who witnessed the incident and no actions taken for late reporting.

Sources: CI, two resident's health records, Investigation Procedures policy and interview with the Administrator. [111]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a witnessed resident to resident abuse incident was immediately

reported to the Director.

Rationale and Summary

A CI was submitted to the Director for a witnessed resident to resident abuse incident that resulted in one resident sustaining an injury. The CI was not submitted to the Director until a number of days later. The CI identified RN #104 as responding to the incident.

The health records for the residents involved indicated an RPN witnessed the incident and reported the incident to an RN. The RN no longer worked in the home. The RPN confirmed they did not report the incident as they thought the RN would be reporting the incident. The Administrator confirmed the Director was not made aware of the abuse incident until a number of days later, when they became aware of the incident and reported it.

Failing to immediately report the witnessed resident to resident abuse resulted in the incident not being immediately investigated or both Substitute Decision Makers (SDMs) being notified.

Sources: CI, two resident's health records, and interviews with registered staff and the Administrator. [111]

WRITTEN NOTIFICATION: Notification re incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee failed to ensure that a resident's SDM, was notified within 12 hours upon the licensee becoming aware of a witnessed incident of abuse of a resident.

Rationale and Summary

A CI was submitted to the Director for a witnessed resident to resident abuse incident that resulted in one resident sustaining an injury. The CI was submitted a number of days after the incident occurred and only one of the resident's SDM was notified of the incident. The DOC confirmed the SDM of the second resident was notified a number of days after the incident when they became aware of the incident and determined their SDM had not yet been notified.

Failing to notify the SDM of one of the residents regarding the abuse incident until a number of days

later leads to mistrust by families.

Sources: CI, health record of a resident and interview with the DOC. [111]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.

The licensee failed to ensure when making the report to the Director for a witnessed resident to resident abuse incident, they included the names of any staff members who were present or discovered the incident.

Rationale and Summary

A CI was submitted to the Director for a resident to resident abuse incident. The CI included only one staff name (an RN). An RPN confirmed they witnessed the incident and they reported the incident to the RN. The Administrator confirmed the CI only included the RN who no longer worked in the home.

Failing to include the names of any staff members who were present or discovered the incident, results in an incomplete investigation into the resident to resident abuse.

Sources: CI, health record of two residents and interviews with registered staff and the Administrator. [111]

COMPLIANCE ORDER CO #001 Directives by Minister

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The home will be compliant with FLTCA, 2021, s. 184(3).

Specifically, the licensee shall:

1. Re-train the IPAC lead and their back-up on the Minister's Directive for COVID-19 guidance document for long-term care homes in Ontario (dated March 31, 2023) related to COVID-19 Self-Assessment audit tools and the frequency of completion when the home is in outbreak.
2. Keep a documented record of the retraining to include the name of the trainer, date the training was provided and who attended the training.
3. Conduct audits for a four week period of time to ensure that the COVID-19 Self-Assessment audit tools are being completed, evaluate the results of the audit and keep track of any breaches in the audits and corrective actions taken and made available to the Inspector upon request.

Grounds

The licensee failed to ensure they carried out every operational or policy directive that applies to the long-term care home, specifically, the licensee did not follow the Minister's Directive related to completing COVID-19 IPAC audits.

Rationale and Summary

Under the COVID-19 guidance document for long-term care homes in Ontario, the home is required to ensure that they complete IPAC audits every two weeks unless in outbreak. When a home is in outbreak, IPAC audits must be completed weekly.

The local public health unit (PHU) declared an outbreak in the home. The home remained in an outbreak at the time of the inspection. The last IPAC audit completed by the home was the week before the outbreak was declared. An RPN (Back up IPAC lead) confirmed there was no other IPAC audits completed, despite the home being in an outbreak a number of weeks later.

Failing to conduct weekly COVID-19 Self-Assessment Audits during an outbreak, places residents at potential risk for transmission of infectious agents.

Sources: CI, Minister's Directive for COVID-19 guidance document for long-term care homes in Ontario (dated March 31, 2023), COVID-19 Self-Assessment Audits, PHU Line Listing, and interview with an RPN. [111]

This order must be complied with by July 10, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice

of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.