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, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2014	2014_220111_0003	O-000817-13	Critical Incident System

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

LYNDA BROWN (111)

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): Janaury 24 & 27, 2014

This inspection was completed concurrently with the RQI inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Behavioural Support Ontario (BSO) team members, and Personal Support Worker (PSW).

During the course of the inspection, the inspector(s) observed 3 residents, reviewed health records of four residents, reviewed the homes investigation and the homes policy on Prevention of Abuse and Neglect.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

A Critical Incident (CI)report was submitted to the Director on a specified date for an alleged incident of resident to resident sexual abuse between Resident #20 and Resident #21.

A second CI report was submitted to the Director on a specified date for a second alleged incident of resident to resident sexual abuse between Resident #20 and Resident #22.

Review of the progress notes for Resident#20 indicated:
-the resident demonstrated 8 incidents of sexually abusive behaviour towards 4 different residents over a 4 month period.
-2 of the 8 incident's resulted in the residents' being harmed or feeling fearful of resident #20.
-during that same time period, the resident demonstrated 8 incident's of potentially harmful interactions between the same four resident's.
-the interventions utilized included: 15 minute checks, 1:1 monitoring, medication, redirection from Resident #21, #22, #23 & #24, DOS & BAT Tool tracking, referral to PASE which recommended keeping resident #20 involved in activities.
-there were inconsistencies in direction for monitoring of Resident #20 (when the resident was on every 15 minute monitoring, 1:1 monitoring, or when to discontinue the monitoring), and when police were to be contacted.

Review of Resident #20 crisis care plan for the same time period:
-did not identify all inappropriate and potential harmful responsive behaviours,
-all the interventions that were utilized to manage the residents inappropriate interactions and sexually abusive behaviours were not identified,
-the specific residents that were being targeted by Resident #20 were not identified,
-the type of monitoring that was to be utilized and when (i.e. every 15 minutes or 1:1).
-there were only two interventions identified to manage the resident's harmful and potentially harmful interactions with other residents.

The licensee failed to ensure that steps were taken to minimize the risk of harmful interactions between resident #20 and four other vulnerable residents. The strategies developed and implemented were inconsistently applied, and the written plan of care was not revised when the strategies utilized were ineffective, to manage Resident #20's continued responsive behaviours of inappropriate sexual behaviour or sexual abuse towards four vulnerable residents.

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 for each resident demonstrating potentially harmful interactions between and among other residents, that steps are taken to minimize the risk, to be implemented voluntarily.

Issued on this 13th day of March, 2014

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

L Brown