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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2018	2018_687607_0006	024475-17	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

JULIET MANDERSON-GRAY (607)

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): March 6, 26, 27 and 28, 2018

During the course of this inspection, two other complaint inspections (Inspection #'s 2018_687607_0004, 2018_687607_0005), (Log #s 023316-17, 024475-17) were completed concurrently related to resident care areas. During this Complaint inspection, non compliance was identified for the Complaint inspection 2018_687_0005 and is being issued under inspection #2018_687607_0006 related to reporting to the Director.

In addition, the following logs were inspected:

Summary of intake Logs:

1) Log #024475-17, a complaint regarding resident care areas, including responsive behaviours, resident to resident abuse and insufficient staffing. A Critical Incident Report was also inspected concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Dietary Manager (DM), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support (BSO) Nurse, Ward Clerk (WC) and Personal Support Workers (PSW)

During the course of the inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, resident to resident interactions, reviewed complaint records and applicable policies.

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

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

- **3 WN(s)**
- **3 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse (RN) who is an employee of the licensee and a member of the regular nursing staff, on duty and present at all times.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 on an identified date, related to staffing.

Review of the RN schedule for a four month period, identified that Agency RN's were utilized for a number of identified shifts.

During interview with Inspector #194, on an identified date and time, an identified staff member indicated that during this period the back fill line for the RN night shift was vacant, one full time RN was on an extended medical leave, and two RN's were on vacation for a two week period.

The identified staff member also verified with Inspector #194, on an identified date and time, while reviewing of the RN schedules that a number of identified shifts on a number of separate identified dates were filled by an agency RN, who was not a member of the regular nursing staff at the home.

An interview with the Executive Director (ED) was conducted by Inspector #194 on an identified date and time, related to the RN staffing at the home. The ED has indicated that currently the home has a vacant RN back fill position for specified shifts, and also has indicated that the position has been vacant for approximately four months. The ED further indicated that the home has posted for three RN positions and is currently conducting interviews. The ED has indicated during the interview with Inspector #194, that the home has a casual pool for RN's at the home consisting of about three RN's and was hoping to increase the number following the interviews.

The licensee failed to ensure that there was at least one registered nurse (RN) who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, specifically related there was no RN who was regular nursing staff present in the home on a number of identified shifts over a four month period. [s. 8. (3)]

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 ensuring that there was at least one registered nurse (RN) who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, 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 abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 on an identified date, related to resident #005's responsive behaviours not being managed well by the Long-Term Care home.

A review of resident #005's progress notes by Inspector #607, indicated that on an

identified date and time, resident #005 was in a specified area speaking with resident #010 and had wanted the resident to get up, in order to walk with resident #010. Resident #010 refused, and resident #005 walked away but returned, then grabbed the resident's body part to get the resident to stand up. Resident #010 yelled and grabbed onto resident #005's body part to release the resident's grip, which in turn caused resident #005 to grab even tighter to the residents body part resulting in an injury. PSW #140 was able to separate the two residents without any further altercation.

During an interview with Inspector #607, on an identified date and time, the RPN #138 who was present and documented the above identified incident in progress notes, confirmed that the incident took place. The RPN further indicated that the incident was reported to the on-call manager at the time, but could not remember which manager it was.

During an interview with Inspector #607 on an identified date and time, the ED indicated not being aware of the above identified incident, therefore the incident was not reported to the Director.

During an interview with Inspector #607 on an identified date and time, an identified staff member indicated being aware of a registered staff member contacting them while on call on the date the incident occurred. The identified staff member indicated directions were not given to the registered staff who contacted them, to report the incident to the Ministry of Health and Long term care (MOHLTC) nor did the identified staff member report the incident to the MOHLTC. The identified staff member further indicated that when there was a resident to resident altercation that resulted in injury to a resident, the MOHLTC should be notified immediately.

The licensee failed to ensure that an identified staff member who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm of the resident, immediately report the suspicion and the information upon which it was based to the Director. [s. 24.]

2. A Critical Incident Report was submitted to the Director on an identified date, regarding an alleged resident to resident abuse that occurred on an identified date and time. The CIR indicated that resident #017 and #019 had an altercation that resulted in an injury to resident #019's body part.

During an interview with Inspector #607 on an identified date and time, the ED indicated

being present in the home at the time and was aware of the incident, but was not sure why the Director was not notified immediately of the identified abuse until the next day.

The licensee failed to ensure the ED who had reasonable grounds to suspect that abuse of a resident #019 by resident #017 had occurred and resulted in harm to the resident, immediately report the suspicion and the information upon which it was based to the Director. [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 ensuring that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours the behavioural triggers for the resident are identified, where possible, strategies are developed and implemented to respond to these behaviours and actions

are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A Critical Incident Report was submitted to the Director on an identified date regarding an alleged resident to resident abuse that occurred on an identified date and time. The CIR indicated that resident #017 and #019 had an altercation that resulted in an injury to resident #019's body part.

A review of the Resident Assessment Protocol (RAPS) for an identified month, identified that resident #019 had several interventions in place related to the resident's responsive behaviours. The RAPS also indicated no referral was needed at the time of the assessment and that the written care plan will be reviewed and updated.

A review of resident #019's current written plan of care had several interventions in place related to responsive behaviours.

A review of resident #019's Kardex had only four interventions in place related to the resident's responsive behaviours, and the responsive behaviours that were identified in the written plan of care and the RAPS were not included in the Kardex.

During an interview with Inspector #607 on an identified date and time, PSW #147 indicated that resident #019 had several identified responsive behaviours and triggers. The PSW also indicated that staff manage these behaviours through redirection, have the resident sit in an identified area, as well as the registered staff would administer as needed medications to the resident.

During an interview with Inspector #607 on an identified date and time RPN #148 indicated that resident #019 has several identified responsive behaviours and indicated that staff would manage the resident's behaviours through redirection.

During an interview with Inspector #607 on an identified date and time the Behavioural Support Ontario (BSO) nurse indicated that resident #019 had several identified responsive behaviours and possible triggers. The BSO nurse also indicated that resident #019 was not apart of the BSO program.

2. The sample size for residents were expanded during the inspection, to include resident #018 as there was non-compliance identified related to responsive behaviours.

A review of the RAPS for a specific month, indicated that resident #018 has several identified responsive behaviours and that the care plan will be reviewed and updated.

A review of resident #018's Kardex related to responsive behaviours, indicated that the resident had several interventions in place. There was no documented evidence of the identified responsive behaviours listed in the Kardex that PSWs has access to.

During an interview on an identified date and time by Inspector #607, PSW #147 indicated that resident #018 has several identified responsive behaviours and triggers.

During an interview with Inspector #607 on an identified date the BSO nurse indicated that resident #018 and #019 has several identified responsive behaviours and triggers. The BSO nurse further indicated that the identified responsive behaviours were not included in the written plan of care or the Kardex, and that the licensee's expectation was that if a resident had identified triggers, the staff were to update the written plan of care, as this was best practice. The BSO nurse also indicated that PSWs do not have access to the written care plans, but has access to the Kardexes and further indicated when interventions were in place, they should be documented in the Kardex.

During an interview with Inspector #607 on an identified date and time the DOC indicated it is the home's expectation that if a resident was exhibiting responsive behaviours, the registered staff would assess the resident and ensure that the resident plan of care reflect the identified triggers and interventions.

The licensee failed to ensure that when resident #018 and #019 had a number of identified responsive behaviours. A review of the written plan of care currently in place had no documented evidence of these behaviours and triggers nor was the Kardex updated to reflect identified behaviours listed in RAPs assessment and the written care plan. [s. 53. (4) (a)]

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 ensuring that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified; strategies were developed and implemented to respond to these behaviours, where possible; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 19th day of September, 2018

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

Original report signed by the inspector.