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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Feb 14, 2020	2020_715672_0003	002177-20	Critical Incident System

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

ReachView Village
130 Reach Street UXBRIDGE ON L9P 1L3

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

JENNIFER BATTEN (672)

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): Febraury 6, 7, 10 and 11, 2020

The following intakes were inspected during this Critical Incident System inspection:

One intake related to a Critical Incident Report regarding a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Administrative Assistant (AA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Aide, Physiotherapist, Resident Services Coordinator/Staff Educator, family members, residents and visitors to the home.

During the course of the inspection, the inspector(s) reviewed health care records, observed residents, reviewed employee training records, schedules and the following policies: Falls Prevention Program, Pain Assessment and Infection Prevention and Control.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director related to a fall sustained by resident #003, which resulted in an identified injury. The CIR indicated that resident #003 was at increased risk for falling and had sustained a specified number of falls in the previous 90 days. At the time of the fall, one of resident #003's fall prevention interventions were noted to not be implemented according to the plan of care. Resident #003 shared the bedroom with resident #004, who indicated they had removed the identified fall prevention interventions, for a specified reason. The CIR indicated resident #004 had a history of removing resident #003's fall prevention strategies.

During record review, Inspector #672 noted resident #003 was at high risk for falling and had several interventions in place as fall prevention strategies. Inspector #672 reviewed resident #003's progress notes from a specified time period, and noted there were multiple incidents where resident #003 was found by staff to not be following identified fall prevention interventions with the assistance of resident #004; and resident #004 had been noted to have removed some of the fall prevention strategies in place for resident #003.

Inspector #672 reviewed resident #003's written plan of care in place at the time of the incident, which indicated the resident required a specified level of assistance from an identified number of staff members for activities of daily living and was at risk for falling. The written plan of care further indicated fall prevention strategies were in place for resident #003 and listed the interventions for staff to implement.

During separate interviews, PSWs #103, #104, #110 and #111 and RPNs #106 and #108 indicated that resident #004 had a history of tampering with resident #003's fall prevention strategies. PSWs #103, #104, #110 and #111 and RPNs #106 and #108 further indicated that prior to resident #003's fall, the only intervention in place to prevent resident #004 from tampering with resident #003's fall prevention strategies was to remind resident #004 not to do so and to request staff assistance for resident #003 instead of providing the assistance. PSWs #103, #104, #110 and #111 and RPNs #106 and #108 indicated resident #004 had an identified level of cognitive impairment and was not able to retain directions or instructions, therefore the intervention of reminding the resident not to tamper with resident #003's fall prevention strategies was not effective.

During an interview, the DOC indicated that resident #004 had a known history of tampering with resident #003's fall prevention strategies, which had contributed to several falls in the past. The DOC further indicated that on the date of resident #003's

fall, several fall prevention interventions listed in the resident's plan of care were noted to not be implemented, which resident #004 indicated they were responsible for. The DOC indicated that prior to resident #003's fall, the only intervention in place to prevent resident #004 from tampering with resident #003's fall prevention strategies was to remind the resident not to do so and to request staff assistance for resident #003 instead of providing the assistance. The DOC indicated resident #004 had an identified level of cognitive impairment and was not able to retain directions or instructions, therefore the intervention of reminding the resident not to tamper with resident #003's fall prevention strategies was not effective. The DOC further indicated that at the time of resident #003's fall, the fall prevention strategies were not provided to the resident as specified in the plan of care due to resident #004 removing resident #003's fall prevention interventions.

The licensee failed to ensure that resident #003's fall prevention strategies were implemented as specified in the plan of care. [s. 6. (7)]

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 care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the immediate and long-term actions that have been taken to correct the situation and prevent recurrence.

A Critical Incident Report (CIR) was submitted to the Director related to a fall sustained by resident #003, which resulted in an identified injury.

During record review, Inspector #672 reviewed the CIR submitted to the Director, and observed the CIR had not included the immediate and long-term actions taken to correct the situation and prevent recurrence of resident #003 falling.

During an interview, the DOC indicated the CIR submitted to the Director did not include the required information. The DOC further indicated they were aware of the legislative requirements regarding the documentation required within the critical incident reports.

The licensee failed to ensure that the report to the Director regarding the fall sustained by resident #003 included the immediate and long-term actions taken to correct the situation and prevent recurrence of resident #003 falling. [s. 107. (4) 4.]

Issued on this 14th day of February, 2020

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

Original report signed by the inspector.