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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2022	2022_984469_0004	018282-21, 000077-22, 000468-22, 001875-22	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

AMA AGYEMANG (722469), SUSAN SEMEREDY (501)

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): The inspection was completed on the following date(s): March 1, 2, 3, & 4, 2022.

The following intake(s) were completed during this Critical Incident System Inspection.

Two intakes were related to falls prevention management;
One intake was related to breakdown of equipment; and
One intake was related to neglect.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Infection Control Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Interim Environmental Services Manager, Restorative Care Aid, Security Staff, and residents.

The Inspector(s) reviewed resident clinical records, care plans, the home's investigation records, relevant polices and procedures, and observed staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents of the home were free from barriers that prevent movement to areas of the home that were generally accessible.

It was observed that a resident was seated in the hallway with a yellow barrier on the floor across the hallway. The barrier was approximately two feet tall from the floor, yellow in colour, and made of a hard plastic. A staff member was also noted seated in the hallway on the opposite side of the barrier. In an interview with the staff member, it was indicated that the barrier was in place because the resident was in isolation. In an interview with the Infection Control Manager, it was confirmed that the barrier was not the home’s standard practice but was being used because the resident had responsive behaviours which may impact adherence isolation requirements.

The risk of placing a barrier across the hallway in this manner created an unsafe environment and increased the risk for potential falls and /or injury.

SOURCES: Observations and interviews with Security Staff and Infection Control Manager. [s. 30. (1) 5.]

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 no resident be restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, to be implemented voluntarily.

WN #2: 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 residents #001 and #005 had strategies developed and implemented to manage responsive behvaiours related to refusing medications.

An RPN observed that resident #001 was refusing medications. The home completed an investigation which included using video surveillance. The conclusion was that resident #001 was offered the medication but when the RPN was not looking expelled the medication. The DOC and RPN indicated that resident #001 was not known for refusing medications prior to this incident. However, a review of the progress notes indicated numerous incidents of refusal before and after the above incident, and a review of the care plan did not identify interventions for management of such refusals.

2. In an interview with an RPN it was indicated that resident #005 often refused their medication. In a review of resident #005's care plan, there was no mention of medication refusals or interventions to manage medication refusals.

With ongoing refusal of medications, resident #001 and #005 were at risk of not receiving the intended therapeutic response of their prescribed medication.

Sources: Resident #001's care plan and progress notes, resident #005's care plan, interview with the DOC and RPNs.

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 responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that actions taken with respect to a resident under the falls prevention and management program including reassessment, interventions and the resident's responses to interventions were documented.

A resident fell and sustained an injury. The resident was at risk for falls and one of the interventions to prevent falls was to have an assistive device at their bedside. Post fall assessments indicated the resident had several falls and most falls were related to the resident attempting to self-transfer using the assistive device. Interviews with the ADOC who is also the lead for the falls program and a Restorative Care Aide (RCA) confirmed the assistive device was noted at one time to be a possible contributing factor in the resident's falls. Review of the care plan indicated that the use of the assistive device as a fall intervention was removed at one point. Interviews with the ADOC and RCA indicated they were attempting to trial the removal of the assistive device, but it was unsuccessful, and the device was reimplemented. The RCA confirmed that the reassessment of the use of the assistive device and the resident's response to the trial were not documented.

Sources: A resident's health record including assessments, written plan of care and progress notes and interviews with the ADOC, RCA and other staff.

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Issued on this 8th day of April, 2022

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

Original report signed by the inspector.