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_727695_0012	001113-17, 003268-17, 009364-17, 012477-17, 014014-17, 014023-17, 024570-17, 024865-17	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

Forest Heights
60 Westheights Drive KITCHENER ON N2N 2A8

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

FARAH_ KHAN (695)

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): September 5, 6, 7, 10, and 11, 2018.

The following Critical Incidents (CIS) were inspected:
Log #001113-17, related to a resident to resident altercation
Log #003268-17, related to a resident to resident altercation
Log #009364-17, related to a resident to resident altercation
Log #012477-17, related to a resident to resident altercation
Log #014014-17, related to a resident to resident altercation
Log #014023-17, related to a resident to resident altercation
Log #024570-17, related to a resident to resident altercation
Log #024865-17, related to a resident to resident altercation

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Behavioural Support Ontario Registered Practical Nurse (BSO RPN), The Educator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, and meeting minutes.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee has failed to ensure that procedures and interventions are implemented that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #003 has a history of responsive behaviours. The written plan of care for resident #003 updated in May of 2017, indicated that there was a certain trigger that aggravated the responsive behaviour.

A record review of progress notes were conducted by Inspector #695 and found that in May of 2018, an altercation occurred between resident #003 and a co-resident. The Behavioural Support Ontario Registered Practical Nurse (BSO RPN) reviewed the incident and updated the written plan of care to include a specific intervention to prevent this type of incident from occurring again.

Upon further record review, Inspector #695 found another altercation occurred in June of 2018, between resident #003 and a co-resident.
On a specific date in July 2018, the BSO RPN wrote a progress note reminding staff to implement the specified intervention which was recommended after the previous altercation in May of 2018.

In an interview with Personal Support Worker (PSW) #111, it was indicated that the PSW was aware of the specified intervention in the plan of care, however it is not always followed.

In an interview with the BSO RPN, it was acknowledged that the specified intervention was updated in the written plan of care in May of 2018. The BSO RPN also acknowledged that if the intervention was implemented, the altercation in June of 2018, could have been prevented between residents.

The licensee has failed to ensure that the specified intervention was implemented to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (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 to ensure that interventions to minimize the risk of altercations and potentially harmful interactions between and among residents are implemented, to be implemented voluntarily.

Issued on this 5th day of October, 2018

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

Original report signed by the inspector.