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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée 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 18, 2020	2020_689586_0004 (A1)	020904-19, 021088-19, 000505-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

West Oak Village
2370 Third Line OAKVILLE ON L6M 4E2

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

Amended by JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Modification made for a change in a resident number.

Issued on this 18th day of February, 2020 (A1)

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

Original report signed by the inspector.

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée 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 18, 2020	2020_689586_0004 (A1)	020904-19, 021088-19, 000505-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

West Oak Village
2370 Third Line OAKVILLE ON L6M 4E2

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

Amended by JESSICA PALADINO (586) - (A1)

Amended 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): January 28, 29, 30 and February 5, 6, 7 and 11, 2020.

The following Critical Incident System (CIS) Inspections were completed concurrently:

020904-19 - Prevention of Abuse & Neglect; Responsive Behaviours;

021088-19 - Prevention of Abuse & Neglect; Responsive Behaviours; and,

000505-20 - Prevention of Abuse & Neglect; Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Behavioural Support Ontario (BSO) Assistant, Pinkertons Security Agents, Registered Practical Nurse (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector toured the home, observed resident care and reviewed resident health records, internal investigation notes, policies and procedures and log books.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that set out the planned care for the resident.

A. According to three CIS reports submitted to the Director in 2019 and 2020, resident #001 was observed displaying an identified behaviour toward resident #002. Resident #001 would seek out resident #002; however, according to progress notes and documentation from resident #001's clinical record, on multiple occasions, resident #002 tried to approach resident #001 as well.

A review of resident #002's written plan of care, which front line staff use to direct care, did not include any information about the above noted behaviours or about resident #001.

In an interview with the DOC, ADOC #111 and ADOC #112, it was identified that they were not aware of resident #002's reciprocating behaviours, and therefore this information was not included in the resident's written plan of care.

B. According to progress notes, on an identified date in 2020, resident #004 was displaying responsive behaviours toward resident #005. Resident #004's substitute-decision (SDM) maker was informed and requested that the home keep the two residents apart. The resident continued to display responsive behaviours toward resident #005 on multiple occasions.

On an identified date in 2020, resident #004 demonstrated physically responsive behaviours toward another co-resident, resident #006. As a result, an identified

interventoin was put into place for resident #004.

The progress notes also documented multiple episodes of another type of responsive behaviour that resident #004 was demonstrating.

Review of resident #004's written plan of care, which front line staff use to directed care, did not include the resident's identified responsive behaviours, targeting of resident #005, or the use of the specific intervention when it was in place. This was acknowledged by the DOC. [s. 6. (1) (a)]

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

According to a CIS submitted to the Director, resident #001 was observed displaying an identified behaviour toward resident #002. Resident #001 would continue to seek out resident #002, therefore a specific intervention was put into place for resident #001.

The resident's written plan of care indicated that specific monitoring was in place to manage these identified responsive behaviours.

According to another CIS submitted to the Director, resident #001 had the specific monitoring in place when they managed to display the identified behaviour toward resident #002 again. According to the home's internal investigation notes, this was witnessed by two staff members, who indicated that staff were unable to intervene in a timely manner. BSO Assistant #100 confirmed in an interview that the incident could have been prevented if the care documented in the resident's plan of care had been provided, therefore care was not provided to resident #001 as specified in the plan of care.

According to a third CIS submitted to the Director, resident #001 had the specific monitoring in place when they managed to display the identified behaviour toward resident #002 again. According to the home's internal investigation notes, the specific monitoring was not in place at that moment. In an interview with BSO Assistant #100, DOC, ADOC #105 and ADOC #106, it was confirmed that the protocol was not followed, therefore care was not provided to resident #001 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 that there iss a written plan of care for each resident that sets out the planned care for the resident, and to ensure that care set out in the plan of care is provided to the resident as specified in the plan, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

The licensee's policy, 'Resident Non-Abuse' (ADMIN-010.01, last reviewed March 31, 2019) indicated that where any person had reasonable grounds to suspect that abuse had occurred, such person must immediately verbally report the suspicion and the information upon which it was abused to the person in charge, who would then immediately report this to their legislative Authority as per legislation.

According to a CIS submitted to the Director on an identified date in 2019, resident #001 was observed displaying an identified behaviour toward resident #002 and this was witnessed by PSW #108. The PSW reported this to registered staff #107, who documented the incident in a progress note. Five days later, the ED met with resident #002's family who brought up the incident. The ED followed up with registered staff #107 who indicated that it had happened but they had not reported it or documented it. As a result, the Director was not notified of the incident until five days later.

The home failed to ensure that a person a person, who had reasonable grounds to suspect abuse of resident #002, failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the LTCHA, pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1). [s. 24. (1) 2.]

Issued on this 18th day of February, 2020 (A1)

[redacted]

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

Original report signed by the inspector.