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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 14, 2013	2013_201167_0004	H-000029-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 30, 31, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, registered staff and personal support worker staff, the identified residents and the home's Behavioural Resource Nurse.

During the course of the inspection, the inspector(s) conducted a review of the health files for three identified residents, reviewed the home's policies and procedures related to Management of Responsive Behaviours and training of staff related to management of the resident with responsive behaviours.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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 did not ensure that written strategies were developed to include techniques and interventions to prevent, minimize and respond to resident # 003's responsive behaviours.
a) A review of the document that the home refers to as the care plan revealed that there were no identified interventions or strategies identified to respond to the resident's physical and verbal aggression towards other residents and to protect other residents and themself from harm related to these altercations. The care plan did not address any increased monitoring activities or identification of the resident's anxiety if other residents were to enter their personal space or go into their room.
b) It was noted in the progress notes for the resident that they frequently refused their medications and this was confirmed by staff interviewed. Resident # 003's care plan did not identify any interventions or strategies to manage this behaviour.
c) The progress notes identified that the resident hoards items, but the care plan does not address any interventions or strategies to manage or minimize this behaviour. [s. 53. (1) 2.]

2. The licensee did not ensure that behavioural triggers were identified for resident # 003.

a) During a review of the progress notes for resident # 003 it was noted that they were demonstrating both verbal and physical aggression towards co-residents frequently. These episodes of aggression were noted to be triggered by others entering their room or invading their personal space.
b) A review of the progress notes also identified that they would become verbally and physically aggressive towards staff when they tried to redirect them.
c) The Minimum Data Set (MDS) assessment dated as January 2013 indicates that the resident had demonstrated the behaviour of wandering, threatening others and hoarding things in a seven day period.
d) During an interview with nursing staff, it was confirmed that the resident did demonstrate these identified behaviours.
e) The document that the home refers to as the care plan did not identify these triggers that were known to precipitate the resident's aggressive behaviours. [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 to ensure that for each resident experiencing responsive behaviours, written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed and to ensure that the behavioural triggers for these residents are identified , where possible., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident # 003 and other residents by identifying and implementing interventions to prevent them.
a) During the month of October 2012, the resident was noted to have had altercations with other residents five times.
During the month of November 2012, the resident was noted to have had altercations with other residents six times.
During the month of December 2012, the resident was noted to have had altercations with other residents 12 times times.
During the month of January 2013, the resident was noted to have had altercations with other residents ten times.
b) In January 2013, the resident # 003 was involved in an altercation with two other residents that resulted in resident # 003 sustaining an injury.

The licensee did not put interventions in place to minimize the risk of these potentially harmful altercations. [s. 54. (b)]

Issued on this 14th day of February, 2013

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

Marilyn Tone