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 11, 2020	2020_530726_0004	000989-20	Complaint

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

Westside
1145 Albion Road ETOBICOKE ON M9V 4J7

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

REBECCA LEUNG (726)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 13, 14, 19, 20, 24, 25, 26, 28 and off-site on March 3 and 9, 2020

The following Complaint intake was inspected during this inspection:
Log #000989-20 related to prevention of abuse and medication administration.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Resident Services Coordinator, Recreation Coordinator, Recreation Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and resident.

During the course of the inspection, the inspector reviewed residents' clinical information and home's correspondence to family member, and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out the planned care for the resident.

The Ministry of Long-Term Care (MLTC) received a complaint from resident #001 regarding concerns with their personal safety in the home after having an altercation with resident #014's family member. The resident also reported a concern related to being given medications at the wrong times.

In an interview, resident #001 stated that a near-miss medication incident occurred to them and they had reported the incident to the nurse-in-charge and was satisfied with the intervention implemented by the home, with no further concerns. The resident then stated they were concerned that resident #014's family member did not always follow the restriction for staying away from them by the specified distance when both of them happened to be waiting for the elevator at the same time in an identified area, and also during the activities inside an identified room. Resident #001 stated that the restriction was imposed on the family member by the home after the altercation happened between them. Resident #001 confirmed they did not feel that they were in immediate risk of harm in the above-mentioned situations, however it brought back the memory of the altercation to them. The inspector then discussed resident #001's concerns with the executive director (ED).

In an interview, the ED stated that they had met with resident #014's family member to reinforce the above-mentioned restriction imposed by the home and they would continue the monitoring.

During the interview, resident #001 brought up another concern that the recreation assistant RA #132 did not follow the intervention of avoiding the resident being brought into the same elevator with resident #015. Resident #001 was unable to recall the date when this incident occurred. Resident #001 stated that the intervention was implemented by the home after the recent altercation between them and resident #015 in an identified location.

Review of an identified assessment indicated that an identified mood indicator was observed on resident #001.

Review of progress note written by RA #132, indicated that on an identified date, when

RA #132 asked resident #015 to attend a program, resident #001 stated that resident #015 could not be in the elevator with them.

Review of progress notes indicated resident #001 had an altercation with resident #015 in an identified location on an identified date. The director of care (DOC) and behavioural support nurse reviewed the video footage recorded by the surveillance camera and found that the altercation was initiated by resident #015 and no injury was documented for both residents.

Review of resident #015's current care plan, indicated that the interventions written under an identified focus included: 1) close monitoring due to altercation with co-resident (#001), 2) keep resident away from co-resident (#001), 3) ensure resident #015 and co-resident (#001) are not in the same common areas unsupervised.

Review of resident #001's current care plan, under the same identified focus indicated there were interventions written related to resident #014's family member and another co-resident (#016). The inspector was unable to find any intervention written related to the prevention of further altercations with resident #015 in resident #001's care plan.

In an interview, RA #132 stated that they were not aware of the previous altercation that occurred between resident #001 and resident #015. When RA #132 was bringing the residents down to attend a program on an identified date, resident #001 told RA #132 that the staff were not supposed to bring resident #015 inside the same elevator with them. RA #132 then left resident #015 in the unit. RA #132 stated that they had read resident #015's care plan and knew that they needed to keep these two residents separated and supervised them at all times. RA #132 acknowledged that the interventions related to resident #015 should also be written in resident #001's care plan, so that the staff on the floor where resident #001 lives, were also aware of the interventions to ensure resident safety.

In an interview with the assigned registered nurse #133 on the floor where resident #001 lives, RN #133 reviewed resident #001's care plan and stated that they were not aware of any intervention implemented related to resident #015. RN #133 acknowledged that the interventions related to resident #001 and any other resident should be written in resident #001's care plan to ensure that the staff on the identified floor were also informed, to prevent any further altercation between resident #001 and the other residents.

In an interview, the assistant director of care (ADOC #135) confirmed that after the altercation occurred between resident #001 and resident #015 on the identified date, the staff on the floor where resident #015 lives, were informed regarding the interventions to be implemented to prevent further altercation between resident #001 and #015; but the staff on the floor where resident #001 lives, were not informed. ADOC #135 acknowledged that the staff on the floor where resident #001 lives should have been informed about the interventions implemented for preventing altercation between the two residents, and the interventions should have been written in resident #001's plan of care to ensure resident safety.

The home has failed to ensure that there was a written plan of care for resident #001 that set out the planned care for the resident related to the prevention of further altercations between the resident and resident #015. [s. 6. (1) (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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 25th day of March, 2020

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

Original report signed by the inspector.