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
Jul 13, 2017	2017_600568_0010	035080-16, 010279-17, 010583-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

DOROTHY GINTHER (568), NUZHAT UDDIN (532)

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): June 1 & 5, 2017

Critical Incident 2707-000064-16 and 2707-000065-16 / log #035080-16 related to a missing resident; Critical Incident 2707-000023-17 / log # 010279-17 and 2707-000024-17 / log # 010583-17 related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, one Registered Practical Nurse and BSO Lead, one Registered Practical Nurse, and four Personal Support Workers.

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

During the course of this inspection, Non-Compliances were issued.

- **2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in the plan of care was provided to the resident as specified in the plan.

Review of a resident's clinical record identified that the resident was witnessed by a staff member exhibiting responsive behaviours towards a co-resident. The staff member intervened and reported the incident to the home. Following the incident, the home put a number of interventions in place to mitigate risk to other residents.

During an interview with a Personal Support Worker (PSW) they told the inspector that a number of interventions had been put in place with respect to the identified resident's responsive behaviours in order to mitigate risk to other residents. The PSW said that one of these specified interventions had been discontinued very soon after the first incident.

During a review of the identified resident's clinical record there was no documentation to indicate that the specified intervention had been discontinued following the initial incident.

During an interview with registered staff, they told the inspector that the decision to alter the specific intervention was usually made by the management of the home with input from staff, and after reviewing relevant assessments and clinical notes. When asked if the registered staff was aware that the specified intervention had been discontinued for the identified resident, they said they had not been notified. The registered staff said that this would usually be documented in the progress notes.

The Director of Care told the inspector that the process for initiating and discontinuing the specified intervention was usually done by the managers, in consultation with BSO and after reviewing relevant clinical records. In the case of the identified resident, the specified intervention had been put in place following the incident of responsive behaviours directed towards another resident. The DOC agreed that there was no documentation that the intervention was discontinued. The DOC acknowledged that the managers had not discussed this resident with respect to discontinuing the specified intervention, and that it would appear to have been miscommunication that lead to the resident not having the specified intervention in place as identified in the plan of care.

The licensee failed to ensure that the identified resident's plan of care was provided to the resident as specified in the plan.

The severity was determined to be a level two as there was potential for actual harm; and the scope of this issue was identified as isolated. The compliance history was a level three, with one or more related noncompliance in the last three years. [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 the care set out in the plan of care was 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident System (CIS) report was submitted to the Director related to an incident where a resident was witnessed by a staff member exhibiting responsive behaviours towards another resident. Staff intervened and reported the incident to the home.

During an interview with the staff member that witnessed the incident, they told the inspector that they observed the identified resident exhibiting responsive behaviours towards a co-resident. They intervened and advised registered staff of the incident. The co-resident seemed upset by the identified resident's behaviours. The staff member shared that the identified resident had exhibited these responsive behaviours towards staff, but they had never seen it directed towards another resident.

Two Personal Support Workers told the inspector that the identified resident often demonstrated these types of responsive behaviours toward staff. Both PSW's said that they had never seen the resident act this way with other residents until the recent incident.

During a review of the identified resident's plan of care it was noted that they exhibited a number of responsive behaviours towards staff and there were interventions in place to manage these behaviours. When interventions had not been effective attempts had been made to change these interventions but the resident's substitute decision maker (SDM) had not been in agreement.

The licensee failed to protect a resident from abuse by another resident.

The severity was determined to be a level two as there was potential for actual harm; and the scope of this issue was identified as isolated. The compliance history was a level three, with one or more related noncompliance in the last three years. [s. 19. (1)]

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 all residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 26th day of September, 2017

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

Original report signed by the inspector.