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

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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
Oct 18, 2017	2017_597655_0014	004788-17, 007826-17, 009922-17	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

HEARTWOOD
201-11TH STREET EAST CORNWALL ON K6H 2Y6

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

MICHELLE EDWARDS (655)

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): August 2, 3, and 4, 2017.

During this inspection, the following logs were inspected concurrently: Log # 004788-17, Log # 007826-17, and Log # 009922-17. Each of the logs were related to allegations of resident-resident abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff (RNs and RPNs), the Dietary Manager, Human Resources, the Director of Care, and the Executive Director.

During the inspection, the Inspector also observed the provision of resident care and services, reviewed resident health care records, policies and procedures, staff training records, and records related to critical incidents including investigation notes.

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)**
- **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. 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 failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #001 and #003, including identifying factors based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

Two Critical Incident Reports (CIRs) - both related to incidents of alleged resident-resident abuse, were submitted to the Director under the Long-term Care Homes Act (2007) on specified dates. Both incidents involved resident #001 and resident #003.

According to the first CIR, resident #001 was observed by a staff member, PSW #100, on a specified date, to be touching co-resident #003 inappropriately.

According to the second CIR, resident #001 was observed by the same staff member, PSW #100, on another specified date, to again be touching resident #003 inappropriately. In the CIR, it was indicated that resident #001 had specifically pursued resident #003 when other co-residents were also seated in the same area. Both residents #001 and #003 were identified in the CIR as having a specified degree of cognitive impairment.

Inspector #655 reviewed the health care record belonging to resident #001.

According to resident #001's health care record, resident #001 had pursued and/or exhibited responsive behaviours which were directed toward resident #003 on a number of additional occasions – all of which occurred prior to the first CIR that was submitted to the Director under the Long-term Care Homes Act (2007). This was confirmed by RPN #107.

According to resident #001's care plan, resident #001 had exhibited specific responsive behaviours from the time of admission. In the same care plan, it was indicated that resident #001 was known to have directed responsive behaviours of a specific nature toward another, unspecified, co-resident on at least one occasion. There was, however, no indication in resident #001's care plan that resident #001 had a tendency to direct responsive behaviours towards individuals of specific characteristics.

Based on a record review and interviews, it was determined that there was an escalation

in resident #001's responsive behaviours beginning at a specified time and that resident #001's responsive behaviours had been increasingly directed toward other co-residents.

During an interview, PSW #100 indicated to Inspector #655 that there had been several incidents involving resident #001, in which resident #001 had exhibited responsive behaviours directed toward co-residents, including resident #003, prior to the first CIR that was submitted to the Director under the Long-term Care Homes Act (2007). According to PSW #100, resident #001 typically directed behaviours towards co-residents of specific characteristics, such as those exhibited by resident #003. According to PSW #100, a standard behaviour monitoring tool was expected to be implemented regularly for resident #001 in order to determine whether there was a pattern in resident #001's behaviours. During the same interview, PSW #100 indicated to Inspector #655 that he/she was unsure for how long the tool had actually been used for resident #001.

During an interview, RPN #107 indicated to Inspector #655 that there had been several incidents involving resident #001, in which resident #001 had exhibited responsive behaviours directed toward co-residents, including resident #003. RPN #107 was aware of the incidents involving resident #001 and resident #003 specifically, which had occurred prior to the incident described in the first CIR. During the same interview, RPN #107 indicated to Inspector #655 that a standard behaviour monitoring tool had been implemented at some time for resident #001; however, RPN #107 did not indicate when the tool had been implemented, nor when it had been discontinued.

Inspector #655 was unable to locate any documentation to indicate that any behaviour monitoring tool was used for resident #001 for any period of time other than a specified one week period following the first CIR, at which time the standard behavioural monitoring tool was utilized. There was no documentation to indicate that a behaviour monitoring tool of any kind had been used for resident #001 when resident #001 was exhibiting responsive behaviours directed at co-residents, including resident #003, in the two months prior to the first CIR.

Inspector #655 reviewed the policy titled "LTC – Dementia Care – Assessment and Care Planning" (CARE3-010.01), dated August 31, 2016, provided to the Inspector by Executive Director (ED) #103. In the section of the policy titled "Responsive Behaviours", it is stated that the monitoring of the types of behaviours exhibited by resident #001 was to be completed using a specific behaviour monitoring tool, designed specifically for the monitoring of the types of behaviours exhibited by resident #001.

Inspector #655 reviewed a copy of the specified behaviour moitoring tool, intended to be used for the purpose of monitoring specific types of responsive behaviours such as those exhibited by resident #001. The tool required the use of codes to describe specific responsive behaviours. It was further indicated on the tool that observers are to make note of several factors when those specific types of behaviours occur, including specific characteristics of the individuals involved.

Over the course of the Inspection, Inspector #655 spoke to several staff members, including PSWs and members of the registered nursing staff. None of the staff members who were interviewed spoke to the use of a tool that was specifically designed for the tracking and monitoring of the specific types of behaviours exhibited by resident #001.

During an interview, DOC #102 indicated to Inspector #655 that both behaviour tracking tools (the standard tool and the tool to be used for the monitoring of specific types of behaviours such as those exhibited by resident #001) are expected to be used when residents display behaviours; the latter to be used specifically for the types of behaviours displayed by resident #001. According to DOC #102, the purpose of the behaviour monitoring tools is to identify patterns and triggers in resident behaviours based on observations.

At the same time, DOC #102 indicated to Inspector #655 that he/she was previously not aware of the tool that was specified for use in monitoring the types of behaviours exhibited by resident #001; and for this reason, no resident exhibiting those specified types of behaviours in the home had been assessed using this tool up to the time of the inspection.

Over the course of the inspection, ED #102 indicated to Inspector #655 that it was not until after the recent incidents described in the two CIRs that specific triggers related to resident #001's responsive behaviours directed at specific co-residents had been identified, such as those characteristics exhibited by resident #003.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #001 and #003, by identifying factors based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations. [s. 54. (a)]

2. The licensee failed to ensure that steps were taken to minimize the risk of altercations

and potentially harmful interactions between residents #001 and #002, including identifying and implementing interventions.

A Critical Incident Report (CIR) related to an incident in which a resident had exhibited responsive behaviours directed toward a co-resident was submitted to the Director under the Long-term Care Homes Act (2007) on a specified date. The incident involved resident #001 and #002; and occurred at a specified time, in a specified location within the home, on a specified date.

According to the CIR, resident #001 was observed by a staff member, PSW #105, to have been touching resident #002 inappropriately. At the time, the two residents were seated next to each other. In the CIR, it is indicated that resident #001 was not to be seated next to resident #002 at the time of the incident.

During an interview, PSW #105 recalled the incident that occurred on a specified date, as described in the CIR. According to PSW #105, resident #001 was sitting next to resident #002 when the incident occurred. The two residents’ were seated close enough together that resident #001 was able to physically reach and touch resident #002. According to PSW #105, resident #001 and resident #002 always sat next to each other when they were seated in a specified location in the home during a specified shift; however, during specified other shifts, resident #001 and resident #002 were not to be seated next to each other when they were seated in that specified location within the home.

During an interview on the same day, PSW #106 indicated to Inspector #655 that due to resident #001's responsive behaviours, resident #001 was to sit apart from other residents during specified periods when the residents were in a specified location of the home. PSW #106 indicated to Inspector #655 that this intervention was put in place for resident #001 shortly after the resident's admission to the home.

During an interview, Staff member #104 indicated to Inspector #655 that resident #001 was to be seated alone when in a specified location of the home - during all shifts, due to the frequency of incidents with co-residents. According to Staff member #104, this was implemented a short time after resident #001’s admission to the home at a specified date. According to Staff member #104, this intervention was in place at the time of the incident. That is, when resident #001 was seated next to resident #002 at the specified time of the incident described in the CIR, resident #001 had not been seated in accordance with the plan.

Over the course of the inspection, Inspector #655 reviewed the care plan belonging to resident #001. The intervention related to the placement of resident #001 when resident #001 was sitting in a specified location of the home was included in the care plan. It was noted, however, that the care plan was not updated to include this direction until five months after the intervention was to be implemented.

During an interview, DOC #102 indicated to Inspector #655 that the direction related to the seating of resident #001 was considered to be an intervention for managing resident #001s' responsive behaviours; and was part of resident #001's plan of care.

The licensee failed to ensure that steps were taken to minimize the risk of potentially harmful interactions between residents #001 and #002, by failing to implement an identifi

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and co-residents, including resident #001 and resident #002, 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date, a Critical Incident Report (CIR) related to an allegation of resident-resident abuse was submitted to the Director under the Long-term Care Homes Act (2007). The incident involved resident #001 and #002; and occurred on a specified date – a number of days before the CIR was submitted to the Director.

According to the CIR, resident #001 was observed by a staff member, PSW #105, to have touched resident #002 inappropriately. According to the CIR, RPN #108 was the staff member who responded to the incident at the time.

During an interview, PSW #105 recalled the incident that occurred on the specified date, in which resident #001 had touched resident #002 inappropriately, as described in the CIR. PSW #105 indicated to Inspector #655 that at the time of the incident, resident #001 was advised that his/her actions were inappropriate. PSW #105 indicated to Inspector #655 that when the incident occurred, it was reported to an RPN immediately.

During an interview, RPN #108 – the same RPN who was identified in the CIR as the staff member who had responded to the incident when it occurred - recalled the incident

that took place on the specified date, as described in the CIR. RPN #108 indicated to Inspector #655 that the incident was reported to him/her by a PSW; and that he/she had documented the incident in a 24-hour report, but had not otherwise reported it. During the same interview, RPN #108 indicated to Inspector #655 that the incident should have been reported. According to RPN #108, the night nurse received the report and reported it to the Director under the Long-term Care Homes Act (2007) the following morning.

According to a progress note written by RN #109, RN #109 notified the on-call manager of the above-described incident the day after the incident occurred.

According to the CIR, however, the incident was reported to the Director under the Long-term Care Homes Act (2007) by Executive Director (ED) #103 a specified number of days after the night RN and on-call manager were made aware.

During an interview, ED #103 indicated to Inspector #655 that he/she had not been aware that the incident until a specified number of days after it occurred. For this reason, the incident was not reported to the Director under the Long-term Care Homes Act (2007) until a specified number of days after the incident occurred.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #002 had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 20th day of October, 2017

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

Original report signed by the inspector.