Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 7, 2019	2019_627138_0014	012012-19, 012245-19	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

Heartwood
201 - 11th Street East CORNWALL ON K6H 2Y6

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

PAULA MACDONALD (138)

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): July 17, 18, 22, 23, 24, 25, 26, 29, and 30, 2019.

Complaint log #012245-19 relating to alleged resident abuse was inspected during this inspection.
Critical Incident System log #012012-19 relating to the same issue of alleged resident abuse was also inspected during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with an activity aide, the Assistant Director of Care, a Behavioural Supports Ontario (BSO) worker, the Director of Care, the Executive Director, a geriatric psychiatry outreach nurse, a physician, the Recreation Manager, registered practical nurses, registered nurses, personal support workers, and a visitor of the home.

The inspector reviewed resident health care records, reviewed internal investigation documents, and observed resident home areas and residents.

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.

- **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. (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 related to medication administration for resident #001 was provided to the resident as set out in the plan of care.

Inspector reviewed a Critical Incident Report submitted to the Director that outlined an incident in which resident #001 had a physical altercation with resident #002 causing resident #002 to sustain injuries.

The plan of care for resident #001 outlined that the resident exhibited responsive behaviours.

One specific intervention for these responsive behaviours listed in the plan of care directed the registered nurses and registered practical nurses to refer to the electronic medication administration record (eMAR) for specific direction with regards to the sequencing of prn (as needed) medication administration.

The eMAR for resident #001 listed three prn medications for responsive behaviours, for the purpose of this report they will be referred to as medication A, medication B, and medication C. The eMAR specifically listed that medication A was the first choice prn medication for resident #001. The inspector spoke with a consulting health professional who stated that medication A was effective in managing resident #001's responsive behaviours and should be the first medication given to resident #001 when responsive behaviours are exhibited. Medications B and C could be used in addition to medication A if the medication A alone was not providing the desired effect on managing responsive behaviours.

On the day of the incident, RPN #103 reported providing resident #001 with prn medications B and C even though the resident had not yet been exhibiting responsive behaviours. Medication A had not been provided at the time. RPN #103 stated that prn medications B and C were given in an effort to be proactive in managing the resident's responsive behaviours. Staff of the home also reported that it could be difficult to give resident #001 prn medications once responsive behaviours were exhibited as the resident would sometimes refuse to take the prn medications.The prn medications B and C provided were documented as given to resident #001 at a specific time that day.

Approximately 15 minutes later, a visitor in the home observed resident #001 to be exhibiting responsive behaviours towards resident #002. Resident #001 was redirected away. Prn medication A was not given as per the plan of care.

Approximately 90 minutes after this, according to the health care record, resident #001 was observed exhibiting responsive behaviours and continued for another hour until

resident #001 came across resident #002 in a hallway. At this time, resident #001 was witnessed by PSW #104 to approach resident #002. PSW #104 described a brief verbal exchange between the two residents followed by physical altercation. PSW #104 stated that they were able to successfully redirect resident #001 away and there was no further interaction between resident #001 and resident #002.

In response to the incident, resident #001 was provided with prn medication A along with another dose of prn medications B and C. The resident settled and no further responsive behaviours were noted that night.

The licensee failed to ensure that the care with respect to the use of prn medications for resident #001 was provided according to the plan of care as medication B and C were provided in the absences of responsive behaviours and prn medication A was not provided at the onset of responsive behaviours. [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 is provided to a resident as specified in the plan, to be implemented voluntarily.

Issued on this 8th day of August, 2019

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

Original report signed by the inspector.