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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Feb 14, 2018	2018_551526_0001	016593-17, 018232-17, 021274-17, 000020-18	Critical Incident System

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

West Oak Village
2370 Third Line OAKVILLE ON L6M 4E2

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

THERESA MCMILLAN (526), LEAH CURLE (585)

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): February 2, 6, 7, 8, and 9, 2018.

During the inspection, the following Critical Incident System (CIS) inspections were completed.
Log #000020-18/ CIS 2870-000001-18 regarding resident elopement;
Log #016593-17/CIS 2870-000010-17 regarding falls prevention;
Log # 018232-17/ CIS 2870-000014-17 regarding responsive behaviours; and
Log #021274-17/ CIS 2870-000016-17 regarding responsive behaviours;

The following on-site inquiries were conducted during this inspection:
Log #018896-17/ CIS 2870-000015-17 regarding responsive behaviours;
Log #022902-17/ CIS 2870-000017-17 regarding missing medications;
Log #023759-17/ CIS 2870-000023-17 regarding alleged staff to resident verbal abuse

Inspector #694 Amanda Coulter was present as an observer during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Directors of Care (ADOC), Registered Practical Nurses (RPNs), the Behavioural Supports Ontario (BSO) staff person and residents.

During the course of this inspection, inspectors reviewed health records, investigative notes, policies, procedures, and training records, and observed residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the care plan was provided to the resident as specified in the plan.

Resident #002 was admitted on a specified day in 2017 and their 24-hour admission care plan titled, “Move In Assessment/Plan of Care” was completed. The care plan and interdisciplinary progress notes identified that the resident had responsive behaviours and outlined interventions to address these. On a specified day, resident #002 exhibited these behaviours which resulted in a risk for harm to the resident. According to the home's investigation notes and interview with RPN #114, care had not been provided to resident #002 in relation to their responsive behaviours as specified in their admission care plan. RPN #114 confirmed the care set out in the resident's care plan was not provided as specified in the plan to ensure resident #002's safety. (#585) [s. 24. (6)]

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 care plan was provided to the resident as specified in the plan, 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 failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents 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, and by identifying and implementing interventions.

According to health records and interviews with Registered Practical Nurse #123, the home’s Behaviour Support Ontario (BSO) staff person, and the Recreation Manager, resident #010 had a history of responsive behaviours.

Review of health records revealed that resident #010 exhibited responsive behaviours that resulted in altercations with co-residents causing harm over a three month time frame. During interview, the BSO staff person stated that, for residents with responsive behaviours, behavioural assessments and interventions for residents should be found in the progress notes and the assessment tab of the home's electronic documentation system. Health records did not include behavioural assessments of resident #010 after any of these altercations with co-residents, or discussions about possible triggers; strategies had not been identified to prevent altercations. The document the home referred to as the care plan did not include interventions related to the prevention of altercations between resident #010 and co-residents. This was confirmed by the home’s BSO staff person during interview.

During interviews, BSO staff, and the Director of Care (DOC) stated that staff should have conducted investigations, identified triggers or contributors if possible, contacted BSO to recommend interventions, entered these into the plan of care, and implemented and evaluated the effectiveness of these interventions to minimize the risk of altercations between resident #010 and co-residents. [s. 54.]

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 residents 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, and by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 14th day of February, 2018

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

Original report signed by the inspector.