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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 26, 2016	2016_229213_0029	025705-16	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

THE MAPLES HOME FOR SENIORS
94 William Street South P.O. Box 400 Tavistock ON N0B 2R0

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

RHONDA KUKOLY (213)

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): August 24, 2016

This inspection was completed related to an anonymous complaint regarding responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, two Registered Practical Nurses, four Personal Support Workers, a resident, and a family member.

The Inspector also made observations and reviewed health records, policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:
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	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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified; (b) strategies were developed and implemented to respond to these behaviours; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions documented.

Resident #001 was admitted to the home on a specified date. Progress notes and incident reports reviewed in Point Click Care included at least thirteen documented incidents of a specified responsive behaviour by resident #001. The first documented incident of the responsive behaviour was the date of admission. The Behavioural Support Team in the home documented time spent with the resident for the first time on thirteen days following admission.

In reviewing the paper chart and electronic health record for resident #001, no completed assessments were found related to the specified responsive behaviour. In a staff interview with the Behaviour Support Personal Support Worker (PSW) on August 24, 2016, the PSW said that they had received a verbal referral for behavioural support for resident #001. The PSW reviewed the health record and said that no assessments had been completed related to responsive behaviours for resident #001.

The plan of care for resident #001 indicated a focus of the specified responsive behaviour, however there were no interventions or directions to staff in how to respond when the resident was exhibiting this specific behaviour. The Behavioural Support PSW agreed that specific triggers for resident #001 the responsive behaviour and specific

interventions when exhibiting this behaviour had not been identified.

An incident report on a specified date, indicated the resident exhibited a specified responsive behaviour resulting in risk of harm. No documentation regarding assessment, reassessment, actions taken, notification of substitute decision maker, care plan review or revision, etc. was present in any documentation.

In a phone interview with the Administrator on August 25, 2016, the Administrator said that the resident had exhibited the responsive behaviour resulting in a potential for risk of harm on three occasions. The Administrator confirmed that assessments related to responsive behaviours had not been completed and the plan of care did not include interventions specific to the specified responsive behaviour resulting in a potential for risk of harm.

The home did not identify behavioural triggers related to resident #001's responsive behaviours, strategies were not developed and implemented to respond to these behaviours, and actions were taken to respond to the responsive behaviour needs of resident #001, including assessments, reassessments and interventions. [s. 53. (4)]

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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 30th day of August, 2016

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

Original report signed by the inspector.