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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2015	2015_287548_0005	O-001726-15	Complaint

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street MAXVILLE ON K0C 1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST MAXVILLE ON K0C 1T0

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

RUZICA SUBOTIC-HOWELL (548), LINDA HARKINS (126)

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): March 5, 2015

During the course of the inspection, the inspector(s) spoke with Residents, Director of Care, Registered Nurses, Registered Practical Nurse, Personal Support Worker.

The following Inspection Protocols were used during this inspection:

Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **0 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and other who provide direct care to Resident # 11.

A progress note entry dated for a specified dated in February,2015 indicated that Resident #10 had an verbal altercation with Resident #11. Resident #10 was easily redirected by staff and provided medication as prescribed.

On specified days in March, 2015 during interviews Registered Nurses S#114 and S#116 and PSW S#115 all indicated that they are aware of the history of altercations between the two residents. All staff indicated that it begins with Resident #10 placing a mobility device in close proximity to Resident's #11 sitting area. Staff indicated that Resident #11 has verbalized that Resident #10 is purposely doing this and blocking access to this area. All three staff members indicated that both residents will exchange negative remarks and that Resident #11 mock and raise a fist at the other resident. All three staff members indicated that they have instructed Resident #10 to place the mobility device away from the other resident's sitting area. RN S#114 indicated that Resident #10 is known to make gestures or noises to co-residents while wandering the home. She indicated that the resident is easily distracted and redirected and does not recall any past altercations.

It is noted there are progress notes entries on specified dates in February, 2015 that described Resident #10 as having altercations with staff and co-residents.

On March 5, 2015 during an interview with inspectors #548 and #126, Resident #11 indicated that when Resident #10 is in close proximity he/she “feels unsafe". Resident #11 indicated that the staff have discouraged close proximity between the two residents in an attempt to dissuade contact.

Resident # 10 health care record was reviewed. It is noted that there is no documentation in the current plan of care, related to redirecting the resident, to have the mobility device set away from the seating area and no specific interventions to ensure the resident's safety by keeping the two residents (Resident #10 and #11) apart and not within close proximity.

Resident #11 health care record was reviewed. It is noted that there is no documentation in the written plan of care related to the mocking behaviour directed to other residents (more specifically Resident # 10) and specific interventions to ensure the safety of Resident #11 by keeping the two residents (Resident # 10 and # 11) apart and not within close proximity of each other.

On March 5, 2015 inspector #548 observed Resident #10 and Resident #11 on three occasions, it is noted that the Resident #10 and Resident #11 did not demonstrate any aggressive or inappropriate behaviour. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug is administered to Resident #10 in accordance with the directions for as specified by the prescriber.

Upon record review it is noted that on February 26, 2015 the Physician prescribed a anti-depressant for Resident's #10.

The Director of Care (DOC) provided to inspector a document titled: Detailed Individual Report on Incidents and Progress Notes dated March 5, 2015. It reads: Feb:26 start Remeron 7.5 mg hs (order not processed- done today).

On March 5, 2015 during interviews the DOC and S#114 confirmed that the medication was not administered to Resident #10 as prescribed. [s. 131. (2)]

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.