Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 5, 2020	2020_593573_0005	002669-20	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

ANANDRAJ NATARAJAN (573)

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): February 24, 25 and 28, 2020, March 01 and 02, 2020.

Log #002669-20 related to nursing staff level on a specified unit and the provision of care to the residents was inspected.

During the course of the inspection, the inspector(s) spoke with residents, the Nursing Administrative Assistant, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI -Coordinator, Unit Managers, the acting Director of Care and the Chief Executive Director.

During the course of the inspection, the inspector reviewed resident health records, bathing schedules, reviewed licensee staffing plan documents and schedule. In addition, the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours
Sufficient Staffing

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	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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and had a convenient and immediate access to it.

Resident #003 and #004 was known to have cognitive impairment, the plan of care in effect identified their responsive behaviours and its interventions respectively.

On February 25, 2020, PSW #101 and PSW #102 stated to Inspector #573 that the resident care was provided as stated in the plan of care (Kardex) paper copy which is kept in the resident's room. Furthermore, they stated that PSW's do not have access to the electronic plan of care for the residents using the home's Medicare system.

On February 25, 2020, Inspector #573 reviewed resident #003 and #004's plan of care (Kardex) which was kept in the resident's room and their electronic plan of care in the Medicare system. It was noted that resident #003's Kardex in the resident's room was not the current plan of care and did not include all the contents of the resident's responsive behaviours and their interventions as identified in the electronic (Medicare) plan of care. Furthermore, resident #004's plan of care (Kardex) did not include all the contents of the resident's responsive behaviours as identified in their electronic (Medicare) plan of care.

Interview with RPN #103 on February 25, 2020, indicated that PSWs access a resident's plan of care via the Kardex in their respective room. The RPN reviewed resident #003's Kardex and stated that the Kardex was not updated and does not include all the contents of the resident's responsive behaviours and their interventions as identified in the

electronic (Medicare) plan of care.

Interview with acting Director of Care on February 27, 2020, confirmed that PSWs only access resident's plan of care via the Kardex at the resident room and that PSWs cannot access a resident's electronic plan of care in the Medicare system.

As such, the direct care nursing staff were not aware of all the contents of resident #003 and #004's plan of care and had a convenient and immediate access to it. [s. 6. (8)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented, specifically in relation to resident #003, #004 and #005's baths.

The plan of care for resident #003, #004 and #005's bathing indicated their preferred method of bath and to have their bath twice a week.

Inspector #573 reviewed resident #003, #004 and #005's PSW documentation in the Daily Care Flow sheet for specified three months. Upon review for resident #003 and #004, it was noted that five scheduled showers/baths for the residents were not documented as being completed. Further, for resident #005, it was noted that 10 scheduled showers/baths for the resident was not documented as being completed. There was no documentation indicating that the above identified residents had refused their baths on the days where the provision of the bath was not documented.

During an interview, RN #104 indicated to the inspector that PSW staff were expected to document the resident's bath in the PSW Daily Care Flow sheet. Upon review of resident #003, #004 and #005's Daily Care Flow sheet, the RN agreed with the inspector that the provision of bath on the identified dates were not documented. Furthermore, the RN indicated that if the provision of the care was not documented then we can also assume that it was not been provided.

As such, the licensee failed to ensure that the provision of the care set out in the plan of care was documented for resident #003, resident #004 and resident #005. [s. 6. (9) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the licensee staffing plan documents revealed that there was no written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

On March 02, 2020, the acting Director of Care indicated to the inspector that the licensee's staffing level plan was reviewed on an ongoing basis. The acting Director of Care acknowledged that the licensee did not have the written documentation related to the annual evaluations of their staffing plan, who was involved in the evaluation, and the changes implemented based on the evaluations. [s. 31. (4)]

Issued on this 5th day of March, 2020

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

Original report signed by the inspector.