Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 19, 2010	2010_134_8540_19Nov111 521	Complaint Log # O-001644

Licensee/Titulaire
Maxville Manor, 80 Mechanic Street, Maxville, ON, K0C 1T0
Fax: 1-613-527-3103

Long-Term Care Home/Foyer de soins de longue durée
Maxville Manor, 80 Mechanic Street, Maxville, ON, K0C 1T0
Fax: 1-613-527-3103

Name of Inspector)/Nom de l'inspecteur(
Colette Asselin # 134

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to one resident's abusive behavior toward residents and staff. .

During the course of the inspection, the inspector spoke with the Director of Nursing, the Registered Nurse in charge of the unit, the evening Registered Practical Nurse, 4 Personal support workers and the resident.

During the course of the inspection, the inspector observed the resident's behavior and reviewed his Health Records.

The following Inspection Protocols were used during this inspection..

1. Responsive Behavior
2. Prevention of Abuse and Neglect
3. Medication Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 6.

(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective.

(11) When a resident is reassessed and the plan of care reviewed and revised,

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Findings:

1. In reviewing the resident's progress notes there are many entries detailing ongoing aggressive and abusive behavior towards staff and residents.

2. The resident's plan of care was not effective in managing behaviors. The plan of care was reviewed quarterly but even though the care set out in the plan was not effective no different approaches to manage the behaviors were considered in the revision of the plan.

3. Upon the resident's return to the home, his electronic care plan was not reviewed and revised to reflect the changes in his condition and needs. The bedside kardex did not provide direction to staff related to changes in his behavior.

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 meeting the requirement that the resident's plan of care is revised when the resident's care needs change and if care set out in the plan is not effective, different approaches are to be considered, to be implemented voluntarily.

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Inspector ID #:	134

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: November 29, 2010