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
Jan 21, 2020	2020_575214_0002	024059-19	Complaint

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

CATHY FEDIASH (214)

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): January 8, 9, 10, 13, 2020.

Please note: This inspection was conducted simultaneously with Critical Incident System inspection #2020_575214_0001 / 024149-19.

The following intake was completed during this complaint inspection:

-024059-19: related to prevention of abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Personal Support Workers (PSW); residents and family members.

During the course of the inspection, the inspector(s) reviewed the complaint intake; home's investigative notes; complaint log; resident clinical records; relevant policy and procedures and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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	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 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 has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident's #002, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

A review of complaint log #024059-19 and a discussion with a family member indicated that on an identified date, resident #002 demonstrated a specified responsive behaviour toward resident #001.

A review of resident #002's progress notes indicated they had been admitted to the home, approximately three weeks prior, to an identified room number. On their admission date, staff heard the resident verbalize an identified comment to their roommates. The progress note indicated that the DOC was made aware of the situation and approved resident #002's move to another room.

A progress note dated approximately three weeks later, indicated that resident #002, was moved to another room for an identified reason. The resident was moved to the room that they had first occupied on their admission date.

A review of progress notes for resident #002, dated the day following this room move, indicated that staff found resident #002, demonstrating a specified responsive behaviour toward resident #001's and verbalizing identified comments to them. Staff responded immediately. Resident #001 was assessed, there were no injuries and resident #002 was immediately moved to a different room.

A review of resident #002's admission Minimum Data Set (MDS), with an identified date, indicated the resident had been coded as demonstrating a specified responsive behaviour, for a specified time period during the review period. A review of the corresponding, narrative Resident Assessment Protocol (RAP), indicated that this assessment had not contained any information regarding why the resident had been coded for the specified responsive behaviour and had not contained any information of the identified situation on their admission, which had resulted in a move to a different room.

During an interview with the DOC, they indicated that steps to minimize the risk of altercations and potentially harmful interactions between resident's, specifically, the factor that had been identified on resident #002's admission day, resulting a room move, had not been included in the resident's RAP. [s. 54. (a)]

2. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident's #002 and #006, including identifying and implementing interventions.

A review of complaint log #024059-19 and a discussion with a family member indicated that on an identified date, resident #002 demonstrated a specified responsive behaviour toward resident #001.

A review of resident #002's progress notes indicated they had been admitted to the home, approximately three weeks prior, to an identified room number. On their admission date, staff heard the resident verbalize an identified comment to their roommates. The progress note indicated that the DOC was made aware of the situation and approved resident #002's move to another room.

A progress note dated approximately three weeks later, indicated that resident #002, was moved to another room for an identified reason. The resident was moved to the room that they had first occupied on their admission date.

A review of progress notes for resident #002, dated the day following this room move, indicated that staff found resident #002, demonstrating a specified responsive behaviour toward resident #001's and verbalizing identified comments to them. Staff responded immediately. Resident #001 was assessed, there were no injuries and resident #002 was immediately moved to a different room.

Five days later, progress notes indicated that while staff were providing care to resident #006, who had been demonstrating an identified responsive behaviour, resident #002 had taken an identified item and carried it close to resident #006. Staff intervened and resident #002 was moved to a different room.

A review of the census tab in Point Click Care (PCC), indicated that resident #001, 003 and 005, had all resided in the same room that resident #002 had been admitted to. The same three residents continued to reside in this room when resident #002 had been moved back into this room and the specified incident above, occurred.

During an interview with the DOC, the above information was reviewed. The DOC indicated that they had not realized that resident #002, had been moved back into the same room that they had been moved from on their admission date, due to a specified reason. The DOC indicated the home conducts frequent room moves due to compatibility concerns and that no system had been in place to track the reason for the room move, including the room number and the resident(s) who had previously resided in the room, when the move was determined to be warranted.

The DOC confirmed that steps had not been taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident's #002 and #006. [s. 54. (b)]

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 ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm as a result of resident #002 ’s behaviours.

A review of complaint log #024059-19 and a discussion with a family member indicated that on an identified date, resident #002 demonstrated a specified responsive behaviour toward resident #001.

A review of resident #002’s progress notes indicated they had been admitted to the home, approximately three weeks prior, to an identified room number. On their admission date, staff heard the resident verbalize an identified comment to their roommates. Staff asked resident #002 what happened, and the resident indicated the roommates were loud. The progress note indicated that the DOC was made aware of the situation and approved resident #002’s move to another room.

Five days later, progress notes indicated that while staff were providing care to resident #006, who had been demonstrating an identified responsive behaviour, resident #002 had taken an identified item and carried it close to resident #006. Staff intervened and resident #002 was moved to a different room.

A review of resident #002’s progress notes dated the day following the incident with resident #001, indicated that a specified intervention had been in place and functioning. A review of the resident’s electronic care plan in PCC, indicated that this specified intervention had been initiated the day after the resident's admission for a specified reason. The same intervention had been put in place for the resident’s identified responsive behaviour, eight days following the incident with resident #001. The care plan indicated under other identified areas, interventions to manage the resident’s specified responsive behaviour. These interventions identified were initiated eight days following the altercation with resident #001 and three days following the potential for altercation with resident #006.

During and interview with the DOC, they confirmed that procedures and interventions had not been developed and implemented to assist residents who were at risk of harm as a result of resident #002’s behaviours, for several days following resident #002’s altercation with resident #001 and potential altercation with resident #006. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents who are at risk of harm as a result of a residents behaviours, to be implemented voluntarily.

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.