Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 25, 30, Aug 1, 2, 2012	2012_031194_0034	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF TAUNTON MILLS
3800 Brock Street North, WHITBY, ON, L1R-3A5

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Regional Manager, Director of Care (DOC), Quality Improvement Nurse, Registered Nurse,(RN), Registered Practical Nurse(RPN), Physician, Personal Care Aides(PCA)and family member

During the course of the inspection, the inspector(s) reviewed clinical health records, and critical incident report and observed identified residents.

Inspector conducted a complaint inspection Log O-000423-12 and a critical incident inspection Log # O-000062-12,(2012_031194_0033)where non compliance was found under section 53(4) and will be issued in this report.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 53(4) (a)(b)(c) when the plans of care for resident #001,#003 and #004 all demonstrating aggressive behaviours, did not identify triggers. Strategies were not developed and implemented to respond to the behaviours, actions were not taken to respond to the needs of the residents, including assessments and reassessments.

Log# O-000423-12

An incident of aggression between resident #001 and resident #002 was reported to MOHLTC.

RPN ,PCA, Physician and management staff have verified that resident #001 exhibits aggressive behaviour towards co-residents.

The progress notes reviewed for the period of three months indicate numerous incidents where resident #001 was aggressive towards co residents.

RAI-MDS assessment for resident #001 indicates an increase in the aggressive behaviour scale.

Implemented Interventions for resident #001 include medication changes and redirection from staff. Clinical health record indicates that resident #001 continued to exhibit aggressive behaviour following interventions.

The plan of care reviewed did not identify the demonstrated aggressive behaviour or behavioural triggers for resident #001. Strategies were not developed and implemented to respond to the identified behaviours. Assessments and reassessments were not completed.

2. Log# O-000062-12 Inspection# 2012_031194_0033

A critical incident report was submitted to MOHLTC reporting a physical altercation between two cognitively impaired residents.

RN, has stated that resident #003 is very territorial with regards to personal space

Recreational staff stated that resident #003 is very protective of personal space specifically towards male residents.

Resident #003 was observed in a physical altercation with co-resident. No injuries
An altercation between resident # 003 and resident # 004, resulted in injury.
Resident #003 was observed in a physical altercation with co-resident. No injuries.

Resident #003 plan of care was reviewed and does not identify the behaviour or aggression when the personal space is invaded . There were no strategies developed to respond to this identified behaviour on the plan of care.

RN, PSW and recreational staff confirm resident #004 was exhibiting wandering/pacing and aggressive behaviour.

Resident #004 plan of care was reviewed and did not identify the wandering/pacing behaviour. There were no triggers listed or strategies developed to respond to this identified behaviour.

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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 ensuring that the identified residents that demonstrate responsive behaviours have triggers identified, strategies developed and implemented to respond to the behaviour and actions taken to respond to the needs of the resident, including assessments, reassessments and intervention for the identified behaviours., to be implemented voluntarily.

Issued on this 3rd day of August, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Chantal Lafrenière (194)