Ontario

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 22, 2015	2015_281542_0021	023430-15, 022711-15	Critical Incident System

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 30, 2015, November 2, 3, 4, 5, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director of Care, the Assistant Director of Care, Registered Staff, Personal Support Workers, Program Manager, Residents and Family Members.

The Inspector reviewed various resident health care records, various policies of the home and observed the delivery of care to the residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan, specifically interventions related to the resident's responsive behaviours.

Inspector #542 reviewed a Critical Incident that was reported to the Director regarding staff to resident abuse towards resident #001.

Inspector #542 reviewed resident #001's most recent care plan accessible to the direct care team. The care plan interventions indicated that if resident #001 was exhibiting responsive behaviors, the staff were to attempt specific interventions first before administering medications. The progress notes regarding this incident did not include any of the specific interventions that were tried prior to the administration of the medications.

On November 3, 2015, Inspector #542 met with the Executive Director/Administrator who confirmed that the registered staff did not follow resident #001's plan of care as they did not attempt to utilize the specific interventions prior to the administration of the medications.[s. 6. (7)]

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 the care set out in the plan of care for resident #001 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24 hour admission care plan was developed and communicated to direct care staff within 24 hours of resident #002's admission with regards to any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

On November 4th, 2015, Inspector #542 spoke with a complainant regarding resident #002. The complainant indicated that on admission they informed the home of specific interventions to use if the resident should exhibit responsive behaviours. They had instructed the home to administer resident #002's medications at a specific time every day, as the resident generally exhibited responsive behaviours around that time. The complainant indicated that during a visit with resident #002 on a specific day, the resident received their medications an hour past the recommended time.

A health care record review was completed for resident #002. On admission the home was provided with an assessment from the Community Care Access Centre (CCAC) that outlined specific interventions that could be useful with decreasing the resident's responsive behaviours. The home was also provided with a "helpful hints" page from Behavioural Supports Ontario (BSO) outlining further interventions that could be used to assist with behaviour management and transition to the home. This was provided to the home two days after the resident's admission to the home.

A review of the current care plan that was available to the direct care staff was completed. The care plan did not include the specific interventions that were provided to the home by the family, CCAC and BSO.

An interview was conducted with the Assistant Director of Care on November 4th, 2015. They confirmed that the interventions were not added to the care plan for the direct care staff and that they should have been included to assist the staff with resident #002's responsive behaviours. [s. 24. (2) 2.]

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 the 24 hour admission care plan is developed and communicated to direct care staff within 24 hours of the resident's admission regarding any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's activity patterns and pursuits.

Inspector #542 completed a health care record review for resident #001. Resident #001 was admitted to the home in May, 2015. The health care record revealed numerous reports from the Behavioural Supports Ontario (BSO) recommending several interventions that were very specific to the resident's likes and dislikes. The interventions listed were to assist the home in minimizing and managing resident #001's responsive behaviors.

Inspector #542 reviewed the most current care plan accessible to the direct care staff. Under the "Activity" section of the care plan, it was noted that the recommendations were not included in the care plan. The care plan did indicate the following under the activity section with regards to an intervention; recreation staff will develop programs pertaining to their interests which they can complete independently.

On November 3, 2015, Inspector #542 spoke with the Program Manager who indicated that they were responsible for creating and updating the Activity section of the resident care plans. The Program Manager verified that the care plan did not mention any of the recommendations from the BSO reports nor did the care plan include any other interventions outlining what types of activities that resident #001 would participate in. The Program Manager stated that they probably did not complete resident #001's care plan as they have been working on other resident care plans. They also mentioned that they were not aware of the specific recommendations made by the BSO with regards to resident #001's responsive behaviors. [s. 26. (3) 16.]

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 resident #001's plan of care is based on, at a minimum, an interdisciplinary assessment of the resident's activity patterns and pursuits, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that they immediately reported the suspicion and the information upon which it was based to the Director, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #542 reviewed a Critical Incident (CI) that was reported to the Director for staff to resident abuse. The CI report indicated that on a specific day, resident #001 became physically aggressive and that a staff member was abusive towards resident #001. The CI was reported to the Director, three days after the incident occurred.

Inspector #542 met with the Executive Director/Administrator, who indicated that they did not know why the CI was not submitted to the Director immediately as they were not present in the home during that time. [s. 24. (1)]

Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.