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

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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
Mar 6, 2015	2014_301561_0023	H-001401-14	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St SHELBURNE ON L0N 1S4

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

DUFFERIN OAKS
151 CENTRE STREET SHELBURNE ON L0N 1S4

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

DARIA TRZOS (561)

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): November 12, 13, 2014.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) Nurse, Social Worker, and Personal Support Workers (PSWs).

Inspector also observed the provision of care, reviewed health records, relevant policies and procedures and interviewed staff.

The following Inspection Protocols were used during this inspection:
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	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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #101's written plan of care indicated that when the resident exhibited verbal and physical aggression staff were to "document summary of each episode, note cause & successful interventions, include frequency and duration". Furthermore, staff were to "initiate behaviour charting to identify why the resident becomes angry or agitated (note time of day, who was present & what proceeded the incident)".

On an identified date in 2014, resident #101 swatted a visitor. This was witnessed by a registered staff member. Progress notes were reviewed and there was no documented summary of the episode with an identified cause and successful interventions; the behaviour charting was not initiated as specified in the plan of care. The registered staff confirmed that the plan of care was not followed. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

Resident #101 demonstrated wandering behaviour, physical and verbal aggression since their admission to the home. The progress notes indicated that there were 20 documented incidents of wandering into other resident's rooms and ten out of these incidents resulted in potential or actual harm to other residents.

The interview with registered staff and PSWs indicated that the resident had been physically and verbally abusive and wandered into other residents' rooms since the admission to the home.
The written plans of care between May 2014, and November 2014, were reviewed and indicated that the interventions related to physical and verbal aggression remained the same and no new interventions were developed to minimize the risk of altercations after responsive behaviours had occurred. There was no evidence that the resident was reassessed and the plan of care revised when the care set out in the plan was not effective. [s. 6. (10) (c)]

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 is provided to the resident as specified in the plan and to 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, care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
b) identifying and implementing interventions.

Resident #101 had exhibited verbal and physical aggression and wandering behaviours towards residents, staff and visitors since their admission to the home in 2014. According to progress notes resident demonstrated a number of documented incidents of wandering into other residents' rooms which resulted in potential harm to other residents and visitors including but not limited to pulling residents from bed, having altercation with other residents, interference with resident equipment, and hitting a visitor.

Resident's plans of care revised in May 2014 and August 2014, indicated that one of the interventions for physical and verbal aggression was to refer the resident to psychogeriatric clinic. Interview with a Registered Nurse and the Behavioural Support Ontario (BSO) Nurse indicated that the home had plans to refer resident to the psychogeriatric clinic after admission but due to an outbreak in the home in February of 2014, the plan was put on hold. Only after an incident in September 2014, when the resident pushed a call bell against another resident's neck at night, did the home take steps to address the responsive behaviour and referred the resident to the psychogeriatric clinic. Interview with PSWs and registered staff and the review of progress notes indicated that the resident demonstrated responsive behaviours that were potentially harmful to other residents since the admission to the home.

The home failed to ensure that the intervention related to psychogeriatric clinic referral that was identified to minimize the risk of altercations and potentially harmful interactions between and among residents was implemented between May 2014 and September 2014. [s. 54.]

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

Issued on this 10th day of April, 2015

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

Original report signed by the inspector.