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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jan 19, 2017	2016_597655_0017	035179-16, 035186-16, 035204-16	Critical Incident System

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street MAXVILLE ON K0C 1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST MAXVILLE ON K0C 1T0

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

MICHELLE JONES (655)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 29 and December 30, 2016; and January 3 and January 4, 2017.

Three Critical Incidents were inspected during this inspection: Logs #035179-16, 035186-16, 035204-16, related to resident-resident altercations.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Nursing Staff (RPNs and RNs), an Activity Aide, a Housekeeping Aide, and the Director of Care (DOC).
The inspector also observed the provision of care and services to residents, staff-resident interactions and resident-resident interactions, reviewed resident health care records, and reviewed home policies.

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.

- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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 :

The licensee failed to ensure that strategies were developed and implemented to respond to resident #001s demonstrated responsive behaviours.

Three Critical Incident Reports (CIRs) were submitted to the Director under the Long-Term Care Homes Act (LTCHA),2007, related to three separate resident-resident altercations occurring over a two day period. In each case, resident #001 demonstrated aggressive responsive behaviours toward another resident (residents #002, #003, and #004, respectively). As a result of the altercations, both residents #003 and #004 sustained injuries.

During the inspection, Inspector #655 reviewed resident #001s healthcare record. On review of the progress notes, Inspector #655 identified two other occasions where resident #001 demonstrated aggressive responsive behaviours; the most recent occurring three days prior to the first critical incident that was reported to the Director under the LTCHA.

During an interview, PSW #101 acknowledged that there had been changes in resident #001s behaviours observed over a specified period of time, prior to the critical incidents. During the interview, however, PSW #101 was unable to speak to any strategies that had been developed or implemented to respond specifically to the aggressive responsive behaviours demonstrated by resident #001 prior to those that were implemented following the incidents outlined in the three CIRs.

Upon review of resident #001s healthcare record, Inspector #655 was also unable to

identify any strategies that had been developed or implemented in response to the responsive behaviours demonstrated by resident #001 on two prior occasions.

During the inspection, Inspector #655 reviewed resident #001s current care plan. There were no identified aggressive behavioural issues in resident #001s care plan; nor were any related strategies identified for responding to resident #001s aggressive responsive behaviours.

During an interview, RPN #112 indicated that resident #001 grabbed resident #003 on a separate occasion which occurred four days before the submitted CIR. RPN #122 indicated that resident #001 had also demonstrated other behaviours over a specified period of time. At the time of the interview, RPN #122 was unable to identify specific strategies that were included in resident #001s plan of care for responding to these responsive behaviours. RPN #122 indicated that when there is such a change in behaviours, a behaviour monitoring tool is implemented. However, RPN #122 was not sure if the behavioural monitoring tool was implemented for resident #001 at the time of the earlier incident. RPN 122 identified a change in one of resident #001s medical treatments as contributing to the recent changes in resident #001s behaviours.

Over the course of the inspection, RPN #109 and DOC #100 also identified the same change in resident #001s medical treatment as contributing to the changes in resident #001s behaviours. According to the residents' healthcare record, the identified medical treatment received by resident #001 was changed approximately one month before the CIRs were submitted to the Director under the LTCHA.

During an interview, PSW #108 indicated that resident #001 first demonstrated aggressive responsive behaviours two or three days before the incident that was outlined in the first CIR submitted to the Director under the LTCHA. PSW #108 indicated that when there is a change in resident behaviours, including any incident of aggressive behaviours, a behaviour monitoring sheet would be implemented for that resident for a minimum of seven days. PSW #108 indicated that the same tool may also be implemented when there is a change in a residents' medical treatment such as the treatment received by resident #001. PSW #108 acknowledged, however, that they are not always made aware when such a medical treatment is changed. According to PSW #108, the behaviour monitoring sheet was not implemented for resident #001 until six days after the CIRs were submitted to the Director under the LTCHA.

During an interview, RPN #111 indicated that there is no formal mechanism in place to

monitor a residents’ response to changes in the medical treatment that resident #001 was receiving.

During an interview, DOC #100 indicated to Inspector #655 that the two incidents of demonstrated responsive behaviours that were identified in the progress notes, occurring prior to the three incidents included in the CIRs submitted to the Director under the LTCHA, would be indicative of a need to reassess resident #001, to implement the behavioural monitoring tool, and update resident #001s care plan.

DOC #100 informed Inspector #655 that the strategies that were developed and implemented in response to resident #001s responsive behaviours were those that were implemented following the incidents outlined in the three CIRs submitted to the Director under the LTCHA. DOC #100 was unable to speak to any specific strategies or interventions that had been implemented in response to the responsive behaviours demonstrated on the two earlier occasions.

When resident #001 demonstrated responsive behaviours on two occasions not included in the CIR submissions, there were no specific strategies developed or implemented in response to those behaviours.

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 for each resident demonstrating responsive behaviours, including resident #001, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

Issued on this 19th day of January, 2017

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

Original report signed by the inspector.