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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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_0001	024149-19	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 8, 9, 10, 13, 2020.

Please note: This inspection was conducted simultaneously with complaint inspection #2020_575214_0002 / 024059-19.

The following intake was completed during this Critical Incident System (CIS) inspection:

-024149-19: related to prevention of abuse and neglect.

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

During the course of the inspection, the inspector(s) reviewed the Critical Incident System (CIS); home's investigative notes; resident clinical records and relevant policy and procedures.

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	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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to resident #007 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of CIS #2661-000027-19, indicated that on an identified date, resident #006 had informed the Administrator that resident #005 demonstrated a specified, responsive behaviour towards co-resident #007, two days prior.

During a review of the home's investigative notes and an interview with the Administrator, it was indicated that while the residents were in an identified location, resident #006 had witnessed resident #005 to verbalize a specified comment to resident #007. The Administrator indicated that resident #006 had not reported this to them until two days later.

During an interview with resident #006, they confirmed that they had witnessed the above incident. An interview with resident #007, indicated that an incident between resident #005 had occurred and that resident #005 had verbalized a specified comment to them. During an interview with resident #005, they indicated they had not verbalized anything to resident #007 and that no altercation had occurred.

A review of progress notes for all resident's involved, indicated that the reported incident that had been made to resident #007, had not been documented in resident #007's clinical record. No documentation was observed of any actions taken including any assessments, reassessments or interventions to ensure the well being of the resident following the reported incident. An interview with the Administrator and DOC confirmed that the reported incident and any actions taken, including assessments, reassessment or interventions, had not been documented in resident #007's clinical record. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.