Ontario

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
Performance Improvement and Compliance Branch
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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
Mar 29, 2011	2011_027621_0001	Critical Incident H-03443 H-03444

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 TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Practical Nurses, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed medical records, reviewed policy and procedure, observed resident interaction.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 sayants :

1. The licensee shall ensure that care set out in the plan of care is provided to the resident as specified in the plan of care.
The plan of care for a specified resident indicates the resident demonstrates a responsive behaviour in specific situations. The resident was not removed to a quiet area as the plan of care indicates is required. The residents responsive behaviour was exacerbated by late afternoon on a specified day.
2. A specified resident's plan of care provides direction for staff regarding management of identified behaviours. It was noted on a specified day that the music played in the lounge on the home area continuously throughout the day. No attempts were made to provide intervention for the resident. The resident's responsive behaviour was exacerbated by late afternoon.
3. The written plan of care for each resident shall set out clear direction to staff and others who provide direct care to the resident.
The Plan of Care for a specified resident includes information related to responsive behaviours. No interventions are identified specifically related to these behaviours. There is no specific information related to protecting the resident or others from the responsive behaviours. Early recognition of responsive behaviours and de-escalation are not addressed.
4. The plan of care for a specified resident includes information related to responsive behavioural episodes directed at staff and co-residents. Interventions provided in the plan of care do not provide staff with information regarding steps to take to avoid these behaviours or how staff can ensure other residents are kept safe.
The behaviours identified are not dealt with in the plan of care. There is no indication of when the behaviours are evident although a review of documentation in the progress notes indicates that the majority of these incidents have occurred on the evening shift.
Particular residents that may trigger behaviours for the resident have not been identified and communicated to staff.

WN #2: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits sayants :

1. Immediate reporting to the Director is required when there is abuse or suspected abuse of a resident by anyone, that results in harm or risk of harm to a resident.
On a specified date, an aggressive incident occurred between two residents. The altercation resulted in injury to one resident. The incident report related to this incident was not received by the Director immediately.
On a second specified date, an aggressive incident occurred between two residents. The altercation resulted in injury to one of the residents. The incident report was not received by the Director immediately

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 subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits sayants :

1. The plan of care does not include interventions related to mood and behaviour patterns, triggers, or variations in resident functioning at different times of the day.
A specified resident demonstrates responsive behaviours often directed at co-residents. The medical record for the specified resident does not contain an interdisciplinary assessment of behaviours that identifies possible triggers for these responsive behaviours, or variations in resident functioning at different times of the day.
A Registered Practical Nurse and the Director of Care indicated during interview that Daily Observation Sheet (DOS) documentation had been completed for the resident. These documents were not available.
Personal Support Workers interviewed were unable to identify triggers for behaviours exhibited by the resident.
A review of incidents documented in the progress notes indicates that these incidents frequently occur during the evening shift. There is no evidence of the incidents having been reviewed for patterns.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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 sayants :

1. Specified residents demonstrated responsive behaviours, no written strategies, including techniques and interventions to prevent, minimize or respond to the responsive behaviours were identified in the plan of care.
A specified resident of the home exhibited responsive behaviours toward co-residents within the home. A DOS record was completed. There is no evidence of analysis of the record.
There are no further assessments related to behaviours even though the resident's behaviours continued to escalate.
2. The plan of care for a specified resident does not provide any indication of triggers for responsive behaviours identified. Interventions identified are not specific to the needs of this resident - e.g. the time of day behaviours are most evident, other residents that should be avoided, how to ensure the safety of all other residents of the home area.
3. A specified resident demonstrates responsive behaviours. These behaviours are not identified in the plan of care including triggers that may initiate the behaviours. The plan of care for the resident does not include techniques and interventions to prevent, minimize or respond to responsive behaviours.

Issued on this 10th day of May, 2011

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

Debora Saville, Nursing Inspector.