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
Sep 30, 2015	2015_339617_0017	021795-15	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

SHEILA CLARK (617)

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): August 19, 20, 21, 2015

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Office Manager (OM), Program Manager (PM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The inspector also conducted a tour of the home, observed resident care, and reviewed resident health care records.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Critical Incident System Report was submitted by the home regarding a mandatory report of resident to resident abuse. Inspector #617 reviewed the report which identified that resident #001 was involved in an altercation with resident #002. Resident #001 was sitting in resident #002's seat in the dining room for lunch. This upset resident #002, who then proceeded to hit the resident #001 on the arm with a clothing protector. Resident #001 responded by standing up and striking resident #002 resulting in an injury to resident #002.

Inspector #617 reviewed progress notes for resident #001 from June to August 2015, which identified several past incidents of responsive behaviours towards other residents and staff.

In a period of approximately three months the resident exhibited several incidents of responsive behaviour which have placed other residents living in the home at risk for physical and emotional injury.

Inspector #617 reviewed the Resident Assessment Instrument-Minimal Data Set (RAI-MDS) assessments dated June 3, 2015, for the resident #001 which indicated that the resident has responsive behaviours.

Inspector #617 reviewed the care plan for the resident which identified that interventions were developed to manage the assessed behaviours with the goal of maintaining resident safety.

Inspector #617 reviewed the resident's health care records which included an assessment by the North East Behavioural Supports Ontario (BSO). The BSO provided recommendations dated July 2015, to manage the responsive behaviours for resident #001 however the home failed to update this information in the resident's plan of care to assist staff in safely managing the behaviours.

On August 21, 2015, resident #003 was interviewed by inspector #617. Resident #003 reported that they were scared of resident #001 with responsive behaviours. Resident

#003 had witnessed resident #001 strike out and yell at other residents, staff and visitors on several occasions.

Inspector #617 observed resident #001 walk down the hallway and yell at a resident who was self propelling in their wheelchair towards the nursing station. The resident became upset then returned back to their room instead of continuing down the hallway. At that time there were two staff members helping a family member at the desk and did not respond to the incident.

On August 19, 2015, inspector #617 interviewed staff #102 and staff #103 who confirmed that the interventions identified in the care plan for the resident #001 have been used to manage their responsive behaviours and were not effective in maintaining the safety of the residents and staff.

The home has assessed and care planned interventions as well as used the BSO resource to manage the responsive behaviours for the resident however it is evident that the interventions for care set out in the plan have not been effective in managing the resident's responsive 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 to ensure that every resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 29th day of October, 2015

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

Original report signed by the inspector.