



**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
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division

Performance Improvement and Compliance Branch

Division de la responsabilisation et de la
performance du système de santé

Direction de l'amélioration de la performance et de la
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 9, 13, 14, 15, 16, 17, 20, 21, 2012	2012_030150_0020	Critical Incident

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

CAROLE BARIL (150)

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, Assistant Director of Care (ADOC), Occupational Therapist (OT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed resident's health care records, the home's Fall Prevention and Management Program, Use of Restraint Policy dated 2010, observed residents activities.

During the course of this inspection the inspector conducted three critical incident inspections, log# O-001528-12, log# O-000325-12, log# O-000465-12.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Minimizing of Restraining

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
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. (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 saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O.2007, s.6 (7), in that the care set out in the plan of care was not provided to the resident as specified in the plan.

An identified resident has a wound history.

The identified resident is seen by the Enterostomal Therapist (ET) monthly for wounds assessment.

In May 2012, the resident's wound was assess by the Enterostomal Therapist (ET) and plan of treatment was prescribed.

In June 2012, an RN applied a dressing to the identified resident's ulcer which was not part of the plan of treatment prescribed.

In June 2012, an RPN completed a dressing change on the resident and the wound condition deteriorated.

In July 2012, the documentation indicates that the wound is healing well.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, 110 (7)4, in that the plan of care did not include the consent by the SDM.

On February 6, 2012, Doctor's order indicates 4 point belt for wheelchair to be used due to high fall risk.

The care plan indicates a restraint with expected outcome to maintain safety when in chair, intervention 4 point belt for wheelchair.

The RN states that they don't have consent sheet for restraints but they inform the family and get a verbal consent and document the verbal consent in the progress notes or on the Dr. order sheet.

No documentation related to restraint consent from SDM was found in the plan of care.

2. The licensee has failed to comply with O.Reg 79/10, 110 (7) 6, in that all assessment, reassessment and monitoring, including the resident's response is documented.

An identified resident has a 4 point belt restraint in place. The resident's restraint observation , repositioning documentation form reviewed for June, July and August, 2012. The section indicated RN/RPN re-assessment for each shift has been inconsistently documented.

The home's policy "Use of Restraint" dated 2010, section 12 (h) indicates The resident's condition is reassessed and the effectiveness of the restraining evaluated by a registered nursing staff and documented at least every eight hours.

Interviewed RN/RPN and they state that they do regular assessment of resident's restraints but that they don't document this assessment as home's policy.

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT
CONFORME AUX EXIGENCES:**

**CORRECTED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:**



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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3.	CO #001	2012_044161_0012	150

Issued on this 21st day of August, 2012

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

A handwritten signature in cursive script, reading "Carol Buil".