



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

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b>  | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|------------------------------------------------|-----------------------------------------------|---------------------------------|----------------------------------------------------|
| Apr 15, 2013                                   | 2013_214146_0023                              | H-001604-<br>12,H-000174<br>-13 | Critical Incident<br>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, L2E-6S5

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

BARBARA NAYKALYK-HUNT (146)

**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): April 11, 12, 2013

This inspection includes two critical incident inspections H-001604-12 and H-000174-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), assistant Director of Care (ADOC), registered staff, Personal Support Workers (PSW'S) and residents.

During the course of the inspection, the inspector(s) reviewed health records, policy and procedures and observed residents.

The following Inspection Protocols were used during this inspection:  
Responsive Behaviours

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   |



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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. 3. Residents' Bill of Rights**



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Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in



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accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).



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21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).
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**Findings/Faits saillants :**

1. The following rights of residents were not respected or promoted:  
every resident has the right to be protected from abuse.
- a. Between the dates of February 2012 and March 2013, seven identified residents were abused by one specific resident. The resident's health record revealed that on 22 separate occasions the resident abused other residents. This information was confirmed by the resident's record, a resident and the staff. [s. 3. (1)]

***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 the following rights of residents are fully respected and promoted:***

- 2. Every resident has the right to be protected from abuse, to be implemented voluntarily.***



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**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:**

**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. 2007, c. 8, ss. 24 (1), 195 (2).**

**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. 2007, c. 8, ss. 24 (1), 195 (2).**

**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).**

**4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).**

**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).**

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**Findings/Faits saillants :**

**1. A person who had reasonable grounds to suspect that any of the following occurred or may have occurred did not immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident.**

**a. According to the health record, resident #001 abused at least seven different residents on 22 occasions between the dates of February 2012 and March 2013. Only two of these incidents were reported to the Director; one in August 2012 and one in March 2013.**

**The licensee has failed to report 20 incidents of abuse of residents. This information was confirmed by the record and the DOC. [s. 24. (1) 2.]**



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**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 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:***  
***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 a resident, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**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. O. Reg. 79/10, s. 53 (1).**
- 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
- 3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
- 4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

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**Findings/Faits saillants :**



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1. There were no written approaches to care developed to meet the needs of the residents with responsive behaviours that included:

screening protocols

assessment

reassessment, and

identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

a. Resident #001 has had 22 documented and witnessed incidents of abuse of residents both in public areas of the home and in the residents' rooms.

The plan of care did not include identification of any triggers to resident #001's behaviours or variations in the responsive behaviours at different times of day.

This information was confirmed by the record, bedside staff and the ADOC. [s. 53. (1) 1.]

2. The following were not developed to meet the needs of residents with responsive behaviours: written strategies, including techniques and interventions to prevent, minimize or respond to the responsive behaviours.

a. Resident #001 has had 22 documented and witnessed incidents of abuse of residents both in public areas of the home and in the residents' rooms.

There are no written approaches to care related to preventing the abuse other than a statement "set limits for acceptable behaviour".

This information was confirmed by the record and the ADOC. [s. 53. (1) 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 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, to be implemented voluntarily.***



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Issued on this 15th day of April, 2013

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

*Barbara Heyhaft-Hurst*