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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2019	2019_546750_0018	017591-19, 019389-19, 019804-19	Critical Incident System

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

Long-Term Care Home/Foyer de soins de longue durée

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

STACEY GUTHRIE (750), JESSICA PALADINO (586)

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): November 19, 20, 21, 22, 25, 26 and 27, 2019.

The following intakes were completed during this critical incident inspection:
017591-19 related to responsive behaviours
019389-19 related to the prevention of abuse and responsive behaviours, and
019804-19 related to responsive behaviours.
This inspection was completed concurrently with complaint inspection 2019_546750_0017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, Resident Assessment Instrument (RAI) coordinator, physiotherapist (PT), Behavioural Support Ontario (BSO), registered nurses (RN), registered practical nurses (RPN) personal support workers (PSW) and residents.

During the course of this inspection, the inspector (s) observed the provisions of resident care, reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policies and procedures and Critical Incident System (CIS) submissions.

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.
- **2 WN(s)**
- **2 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD. AMP (s) may be issued under section 156.1 of the LTCHA

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 :

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

A review of Critical Incident (CI) log #019389-19 reported on a specified date, resident #004 was pushing another resident down the hallway, when they came upon resident #005. Resident #004 stopped and inappropriately grabbed resident #005 while standing behind them. Resident #004 continued to walk again a few steps and then returned to grab resident #005 again from behind. Resident #004 continued again to walking down the hall and then grabbed and pinched resident #005 for a third time. The third incident was witnessed by staff who intervened. The other incidents were reviewed via the home's security camera.

A review of the written plan of care for resident #004 found that resident #004 had a referral for Behavioural Support Ontario (BSO) on an identified date and a responsive behaviour assessment completed on another identified date for an different incident. There was no responsive behaviour assessment found for the reported incident.

Resident #005's written plan of care was reviewed and found no evidence that their care plan was reviewed or revised after the reported incident.

In an interview with Registered Practical Nurse (RPN) # 112, they confirmed that they did not complete a responsive behaviours assessment for resident #004 after the reported incident involving resident #005 and they should have.

In an interview with the Director of Care (DOC) #101, they acknowledged that resident #004 and resident #005's care plans should have been reviewed and revised following an incident such as reported.

The home failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan of care was not effective.

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 the licensee shall ensure that residents are assessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #005 from abuse by resident #004.

A review of CI log #019389-19, reported on an identified date, resident #004 was pushing another resident down the hallway, when they came upon resident #005. Resident #004 stopped and inappropriately grabbed resident #005 while standing behind them. Resident #004 continued to walk a few steps and then returned to grab resident #005 again from behind. Resident #004 continued again to walk down the hall and then turned around, grabbed and pinched resident #005 for a third time. The third incident was witnessed by staff who intervened. The other incidents were reviewed via the home's surveillance camera.

In interviews with both personal support worker (PSW) #114 and Registered Practical Nurse (RPN) #112 who witnessed the incident, they confirmed that resident #004 grabbed resident #005 in front of the nursing station. PSW #114 intervened, telling resident #004 to stop which they did immediately, before continuing down the hall. PSW #114 acknowledged that resident #005 would not be able to provide consent due to their impaired cognition and also noted that they did not witness resident #005 give resident #004 consent to touch them when PSW #114 witnessed the incident. PSW #114 reported that resident #005 did not react the situation when it happened and did not appear to be fearful or exhibit any changed behaviour following the incident. Both staff reported to their knowledge there have been no additional incidents since between the two residents.

In an interview with the Director of Care (DOC) #101, they confirmed that they reviewed the surveillance camera and discovered that resident #004 did grabbed resident #005 three times in the reported incident.

The DOC #101 confirmed that the incident reported met the definition of abuse as outlined in the O. Reg. 79/10.

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 The licensee shall protect residents from abuse by anyone, to be implemented voluntarily.

Issued on this 13th day of December, 2019

[redacted]

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

Original report signed by the inspector.