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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 3, 2020	2020_837750_0004	000956-20, 003692-20	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), KELLY CHUCKRY (611), MICHELLE WARRENER (107)

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): February 19, 20, 21, 24, 25, 26, 27, 28, and March 2, 3, 4, 5, 6, 9, 10, 11, 12, and 13, 2020.

The following intakes were completed during this critical incident inspection:
Log #000956-20 related to the prevention of abuse and neglect, and
Log #003692-20 related to the prevention of falls.
This inspection was completed concurrently with complaint inspection #2020_837750_0005.

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:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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. (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 :

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A critical incident (CI) was submitted to the Director in relation to resident #005 experiencing a fall resulting in hospitalization and a change in resident's condition. According to the CI report, resident #005 fell on an identified date, and was assessed accordingly and found to have no injury or concern at that time. Resident #005 continued to be assessed following the incident and on an identified date, the resident was assessed by the home's physician and sent to hospital. Resident #005 was determined to have an injury.

A review of resident #005's written plan of care indicated a fall prevention strategy to include the placement of a falls prevention equipment in a specified location at times outlined in the written plan of care.

During two separate observations on specified dates, resident was observed in bed without the falls prevention equipment in place.

In an interview with Personal Support Worker (PSW) #117 they confirmed current fall prevention strategies for resident #005 included the specified equipment to be placed in an identified location at times specified in the the written plan of care.

On a specified date, PSW #117 attended resident's room with inspector #750 and confirmed that the equipment was not in place as required.

The licensee failed to ensure that the care set out in the plan of care for resident #005 was provided as specified in the plan.

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

A CI was submitted to the Director on an identified date, regarding an incident involving resident #005 who had a fall on a specified date, at which time resident was assessed and there was no injury, hospitalization or change in status. On a later identified date, resident #005 was sent to hospital after being assessed and resident #005 was determined to have an injury resulting in a significant change in their health condition.

The injury was reported to the home on a specified date, and a follow up report was found in resident #005's clinical record three days later. Three days after the note, the resident returned to the home.

In an interview with the DOC #104, they confirmed that the submission of the CIS was late, exceeding the allotted time of one business day to report to the Director after the occurrence of the incident that caused resident #005 injury requiring hospitalization and a significant change in resident #005's health condition

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Issued on this 8th day of June, 2020

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

Original report signed by the inspector.