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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 27, 2021	2021_877632_0009	005393-21	Complaint

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

YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 30, 31, April 1, 9 and 12, 2021.

The following Complaint intake was completed:
log #005393-21 - related to Prevention of Abuse and Neglect, Responsive Behaviors.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Minimum Data Set (MDS) - Residents Assessment Instrument (RAI) Co-ordinator, Clinical Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) observed and interviewed residents and staff, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

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)**
- **0 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. 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with s. 24. (1) (2) in that a person, who had reasonable grounds to suspect abuse of a resident by anyone resulted in harm or risk of harm to the resident failed immediately to report the suspicion and the information upon which it was based to the Director. Pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1).

The Client Services Response Form indicated that the resident had a concern with one of the registered staff actions related to alleged abuse.

The DOC and the Administrator indicated that the home did not complete identified activity as required by the Ministry of Long-Term Care (MLTC) as it was the resident's wish to perform the specified action by the home.

Sources: Client Services Response Form; interviews with the resident, the DOC and the Administrator. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan included, at minimum, the following with respect to the resident: 2. Any risks the resident might pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

A complaint was submitted to the MLTC alleging staff to the resident's abuse.

An RPN indicated that the resident’s Visual/Bedside Kardex Report print out was received by the home provided staff with the specified directions when dealing with the resident.

Progress notes indicated that on an identified date in March 2021, the resident was on an identified protocol.

The video footage identified that on an identified date in March 2021, an RPN performed specified activities, which were specifically described by the resident.

The resident’s 24 hour admission care plan identified no specified triggers and safety measures.

The MDS-RAI Co-ordinator indicated that the 24 hour admission care plan for newly admitted residents was to be created by any registered staff or by the MDS-RAI Co-ordinator and updated during the period of 21 days.

The DOC and the Administrator acknowledged that the 24 hour admission care plan did not include any specified behavioural triggers and safety measures for the resident.

The resident was at risk of exhibiting specified behaviours as a result of their 24 hour admission care plan not identifying any potential specified behavioural triggers and safety measures.

Sources: Complaint log #005393-21, the resident’s progress notes, Visual/Bedside Kardex Report and 24 hour admission care plan, video footage (dated March 23, 2021); interviews with the RPNs, the MDS-RAI Co-ordinator, the DOC and the Administrator. [s. 24. (2) 2.]

Issued on this 4th day of May, 2021

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

Original report signed by the inspector.