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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 9, 2021	2021_704682_0013	006181-21, 006742-21, 010302-21	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

AILEEN GRABA (682), LISA BOS (683)

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): July 19, 20, 21, 22, 23, 26, 27, 28, 2021.

The following Critical Incident System inspection(s) were completed
006181-21 related to fall prevention
006742-21 related to fall prevention
010302-21 related to fall prevention.

This Critical Incident System inspection(s) was done concurrently with Compliance Order follow up inspection 2021_704682_0012.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Supervisor, Environmental Manager, Quality Improvement and Risk Management staff, Housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspector observed the provision of the care and infection prevention and control (IPAC) practices, reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, temperature logs, policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

The licensee's Mechanical Lift and Transferring policy stated that two staff must always be present while the mechanical device was in operation - "HANDS ON".

A resident required assistance with transfers and used a transfer device. The resident was left unattended and sustained a fall. The Director of Care (DOC) confirmed that personal support worker (PSW) staff were not within reach of the resident and did not use safe transferring technique during the incident involving the resident. The resident was placed at risk for injury when the PSW's were not within reach and present when the mechanical device was in operation.

Sources: The licensee's Mechanical Lift and Transferring Devices policy; CIS , electronic medical record (EMR), the home's investigation notes, Interviews with DOC and other staff. [s. 36.]

2. The licensee's SLATE (Safe Lifts, Ambulation and Transfers for Everyone) policy stated that residents found on the floor were transferred from the floor with the use of a mechanical lift. The policy also directed staff to use a "no -lift" philosophy, protecting the residents and staff from injury.

A) A resident sustained an injury related to a fall. A PSW was waiting for transfer assistance from another staff, when the resident was witnessed falling by the PSW. A registered practical nurse (RPN) documented that at the time of the incident, the resident was not exhibiting any pain and was assisted up from the floor to standing position by two PSW's.

A RPN stated that a mechanical lift was not used by PSW staff to get the resident from the floor. The Director of Care (DOC) confirmed that two staff lifted the resident from the floor and did not use safe transferring techniques. Because staff did not use safe transferring techniques when assisting the resident from the floor, the resident was placed a risk for injury.

Sources: The licensee's lift and transfer policy titled: SLATE (Safe Lifts, Ambulation and Transfers for Everyone); CIS,electronic medical record (EMR), the home's investigation notes, Interviews with DOC and other staff.

B) A resident was admitted to the home and had a risk of falls. They sustained a fall and as per the Critical Incident (CI) report and the post fall assessment, after being assessed for injury they were assisted using two staff assistance. The resident expressed pain and was diagnosed with an injury requiring surgical intervention.

Inspector #683 reviewed the CI report with a PSW, who responded to the resident's fall, and they acknowledged that they used two person assistance to lift the resident up off the floor.

In interviews with a RPN and the DOC, they indicated that the home had a zero lift policy and that staff were to use a mechanical lift to assist a resident up off the floor after a fall. By failing to use a safe transferring technique to assist the resident up off the floor after their fall, staff placed the resident at risk for further injury.

Sources: CI report; The licensee's lift and transfer policy titled: SLATE (Safe Lifts, Ambulation and Transfers for Everyone); resident clinical record; interviews with PSW's, RPN, the DOC and other staff. (683) [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing at a minimum, in at least two residents bedrooms in different parts of the home and one resident common area on every floor of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home's temperature logs were reviewed and did not include any resident bedroom temperatures. Both the Administrator and a RPN stated that they have not been measuring temperatures in resident bedroom areas.

By not recording temperatures in at least two resident bedrooms in different parts of the home as per required frequencies, there was risk that inappropriate temperatures may not have been identified.

Sources: Temperature logs; interview with the Administrator and RPN [s. 21. (2) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

A resident was observed in their wheelchair tilted and their feet were unable to touch the ground. The resident identified that they wished their feet touched the ground and were not dangling.

A review of the resident's plan of care did not identify the use of a tilt wheelchair as a PASD. In an interview with the RAI-Coordinator, they confirmed that the resident's plan of care did not identify the use of a tilt wheelchair and that staff should not have placed the resident in that position. They acknowledged that the tilt wheelchair met the definition of a PASD that limited or inhibited a resident's freedom of movement.

Sources: Resident's clinical record; observations; interview with the RAI-Coordinator and other staff. [s. 33. (3)]

Issued on this 11th day of August, 2021

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

Original report signed by the inspector.