Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: November 5, 2024

Inspection Number: 2024-1259-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Maplewood Nursing Home Limited

Long Term Care Home and City: Cedarwood Village, Simcoe

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3, 4, 16, 17, 18, 22, 23, 24, 2024.

The following intake(s) were inspected:

- Intake: #00121661 - Follow-up for compliance order (CO) #006 from inspection 2024-1259-0002 related to O. Reg. 246/22 - s. 58 (4) (c) Responsive behaviours;
- Intake: #00123698 - Critical Incident System (CIS) report #2768-000021-24, related to fall prevention and management;
- Intake: #00125759 - Complaint related to maintenance of equipment, air temperatures and meals;
- Intake: #00125908 - CIS #2768-000027-24, related to an infectious disease Outbreak;
- Intake: #00128643 - Complaint related to resident care concerns;
- Intake: #00129323 - Complaint related to fall prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #006 from Inspection #2024-1259-0002 related to O. Reg. 246/22, s. 58 (4) (c).

The following **Inspection Protocols** were used during this inspection:

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bed rails

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee failed to ensure that where bed rails were used, a resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Rationale and Summary
A resident was using a specific assistive device. The resident then changed rooms and was provided with a different type of assistive device by the licensee. The physiotherapist (PT) confirmed that the resident had never been assessed for the use of the the different type of assistive device. The resident also confirmed they had not been assessed for the use of the different type of assistive device.

The resident indicated that they had sustained injuries related to use of the different assistive device. There was a risk for more serious injury during transfers when using a device for which the resident had not been assessed.

Sources: observations of the resident's room; review of assessments, care plan, and progress notes; and interviews with the resident, and the PT.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)
Plan of care
Based on assessment of resident

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Rationale and Summary
A resident stated they originally used a specific assistive device.

A review of the plan of care did not indicate that an assessment for the use of the assistive device had been conducted. The physiotherapist (PT) stated that they would typically be involved in assessing assistive devices, and confirm that there were no assessments performed before the implementation of the assistive device.

Sources: review of assessments, progress notes, and care plan; interviews with the PT.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident received proper accommodations consistent with their needs.

Rationale and Summary
A resident had a specific room layout that allowed them to access certain items. When the layout of the resident's room changed, they no longer had the space required to access their personal items.

The resident's plan of care indicated a change in the resident's room layout which then allowed the resident to access certain personal items; however, then other items were no longer safely accessible.

The resident was negatively impacted when they could not access their regularly used items, and there was a risk for the resident to injure themselves while attempting to access other personal items.

Sources: observations; review of progress notes; and interviews with the resident, the Administrator, and the Director of Care.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that when a new intervention was implemented for a resident, that the intervention was documented within all necessary plan of care records to ensure that all direct care staff had convenient and immediate access to the intervention details.

Rationale and summary:
An observation of the resident's room showed the intervention was in place.

A clinical record review for the resident showed there was a lack of documentation in the plan of care to indicate the home's rationale for the implementation of the intervention, and to provide a convenient and immediately accessible record for both registered and non-registered nursing staff to reference.

Registered Practical Nurse (RPN) said, they had not documented the intervention to support convenient and immediate access to it by all direct care staff and should have. The lack of documentation in convenient and immediately accessible records impacted the resident's right to ensure all direct care staff were kept aware of the intervention and increased the resident's risk of a lack of care consistent with their needs.

Sources: Clinical record reviews, observations and interviews with staff and management.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee has failed to ensure that when a resident had an incident for which the licensee was unable to determine if the incident resulted in a significant change in the resident's health condition, that the Director was informed of the incident no later than three business days after the occurrence of the incident.

The Ministry of Long-Term Care (MLTC) received a complaint related to a resident's incident and the home's management of the incident.

Rationale and summary
A review of the resident's clinical records, prior to the incident, documented the resident engaged in certain activities of daily living (ADLs). After the incident the resident's ADLs changed, for which the licensee did not have sufficient information to determine whether there was a significant change in the resident's health condition.

LTCH staff interviews supported the resident's activities of daily living changed, and staff did not have sufficient information to make a well informed determination as to whether a significant change had occurred to the resident's health condition.

When the licensee failed to submit a critical incident report, it impacted the resident's right to have any health condition changes identified by the licensee, and increased the risk of a lack of care necessary to meet the resident's evolving care needs.

Sources: Complaint, clinical record review and interviews with staff and management.

COMPLIANCE ORDER CO #001 Plan of care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 7.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Offer safe transfer device options to the resident. Keep a record of which device options were offered and what was the response of the resident.
B) Complete an assessment of the resident which identifies their current transfer status, noting any assistive devices which may be required for the resident to safely transfer.
C) Maintain a record of the assessment including who completed the assessment and the outcome of the assessment.

D) Implement any interventions which the resident may require for safely transferring, and update the plan of care to include any interventions used for transferring.
E) Monitor the resident twice weekly for ongoing, safe use of the chosen transfer device. Keep a record of the monitoring, including the date, who completed the monitoring, any safety concerns noted during monitoring, and any corrective actions taken to ensure the resident's safe transferring. Monitoring and record keeping to continue until this order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the resident's plan of care was based on, at a minimum, an interdisciplinary assessment of the type and level of assistance that was required for the resident's activities of daily living (ADL).

Rationale and Summary
A resident was originally using a certain type of assistive device. Which was changed to a different assistive device by the licensee.

The PT confirmed that the resident had never been assessed for the use of the different assistive device to minimize risk to the resident.

The resident indicated that they had sustained injuries related to the use of the unassessed assistive device which increased their risk for more serious injury.

Sources: the resident's care plan, progress notes, assessments; observations of the resident; and interviews with the PT and the resident.

This order must be complied with by November 15, 2024

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.