Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2016	2016_240506_0018	027652-16	Critical Incident System

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

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

LESLEY EDWARDS (506)

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): September 13 and 14, 2016

Concerns that were identified to be reviewed while at the home were as follows:

Item # 1- Abuse and Neglect.
Item # 2- Plan of Care.

Follow-up inspection was also completed with this inspection:

025490-16- Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, residents and families.

During the course of the inspection the inspector observed the provision of care, toured the home, reviewed clinical records, policies and procedures, investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Pain
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 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	Legendé 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. 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 ensure that resident #001 was protected from abuse by anyone and free from neglect by the licensee or staff.

Resident #001 returned to the Long Term Care home from hospital in July 2016. The resident's Power of Attorney (POA) indicated that the resident's level of mobility declined after re-admission from the hospital. Resident #001 also had a care plan in place to prevent constipation related to decreased mobility. The care plan directed staff to follow the home's bowel protocol which was: registered staff to administer 30 millilitres (mls) of Milk of Magnesia (MOM) if the resident did not have a bowel movement (BM) for two days, then administer a glycerin suppository if no BM for three days, and if no BM for four days, administer a Fleet enema. This protocol was also ordered by the resident's physician.

A review of resident #001's clinical record confirmed that the home was not following the bowel routine as the resident was not receiving the interventions as ordered.

The resident did not receive the interventions in accordance with the home's policy on 13 occasions during the months of July, August and September 2016. At this time the resident was unwell and was sent to the hospital as a result of a complication of the home not following the bowel routine.

The home had another policy which indicated that all residents would be on a bowel management program that promoted regular bowel movements and an individualized bowel routine was to be developed for each resident. The policy directed staff to complete a full abdominal assessment, including but not limited to, auscultation for bowel sounds. It was the expectation according to the DOC that if a resident refused their bowel protocol, the registered staff were to complete an abdominal assessment and document their assessments. In interviews with registered staff #'s 100, 101, 103, 104, 106 and 107, all confirmed that they were aware of this policy; however, did not document their assessments as required.

A review of the clinical record showed on two occasions that an abdominal assessment was completed. Resident #001's documented plan of care under constipation also directed staff to be monitoring for signs and symptoms of constipation and if the resident was experiencing these symptoms, they were to report to the physician. Resident #001 was experiencing symptoms of constipation on an identified date in August 2016 and an identified date in September 2016, the resident was expressing they were experiencing more symptoms of constipation and on another identified date in September 2016, the resident was not eating well and noted to be experiencing more symptoms of constipation. There was documentation in the progress notes on an identified date in

September 2016, that the resident's physician and the Nurse Practitioner (NP) were not available and the resident's POA did not want the on -call physician to be called. The resident was scheduled for a regular medical appointment and the home decided to send the resident to their appointment with a transfer sheet and assessments and a note in the communication book to have the resident assessed at the hospital by their physician or in emergency. The resident returned back from their appointment with orders to hold a medication and reassess next week. The resident was not responding appropriately and not looking well. The NP was called and the resident was sent to the hospital. The DOC confirmed that the physician should have been notified prior to sending the resident to hospital, as the resident was showing signs and symptoms of constipation.

The resident was admitted to the hospital with a medical diagnosis and later deceased in the hospital. The DOC confirmed that the home investigated the care given to resident #001 and confirmed that the home neglected the resident by not following their bowel protocol by completing and documenting the assessments of the resident. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

1. 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.

Resident #001's plan of care directed staff to monitor for signs and symptoms of constipation such as changes in mental status, confusion, sleepiness and vomiting and report to physician. Resident #001 was experiencing signs and symptoms of constipation on identified dates in August and September 2016. The DOC confirmed that the plan of care was not followed as the staff should have notified the physician as outlined in the resident's plan of care. [s. 6. (7)]

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 the care set out in the plan is provided, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy, system
instituted or otherwise put in place was complied with.

The home had a protocol "Bowel Management Program – Home Specific Policy, Resident Care Manual" VII-D-10.70, last revised July 2015," directed registered staff to administer 30 mls of MOM if the resident did not have a BM for two days, then administer a glycerin suppository if no BM for three days, and if no BM for four days, administer a Fleet enema.

A review of the clinical record for resident #001 identified that staff did not consistently comply with the home's protocol.

i. The resident did not receive the interventions in accordance with the home's policy on three occasions and it was not until six days later when the resident received their first intervention on identified dates in July and August 2016.
ii. The resident did not receive the interventions in accordance with the home's policy on three occasions and it was not until six days later when the resident received their first intervention and this intervention was not effective on identified dates in August 2016.
iii. The resident did not receive the interventions in accordance with the home's policy on two occasions in August 2016.
iv. The resident did not receive the interventions in accordance with the home's policy on five occasions on identified dates in July and August 2016. The resident was unwell and was sent to the hospital as a result of a complication of the home not following the bowel routine.

An interview was conducted with the DOC on an identified date in September 2016, which confirmed that the home's protocol was not complied with. [s. 8. (1) (b)]

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 the home's protocol for bowel management is followed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all drugs were administered to resident #001 in accordance with direction for use specified by the prescriber.

Resident #001 had a physician's order for medication to be given. Staff #100 held the medication because the resident was drowsy and did not eat well. The home's policy "Diabetes Management- Sick Days" directed staff to continue to provide diabetic medication or insulin, even if the resident is having trouble eating or drinking and report to the physician. Interview with staff #100 confirmed that they did not give the insulin as prescribed and were unaware of the policy for Diabetes Management- Sick Days. [s. 131. (2)]

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 all drugs that are prescribed are administered, to be implemented voluntarily.

Issued on this 3rd day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2016_240506_0018
Log No. / Registre no:	027652-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 23, 2016
Licensee / Titulaire de permis :	2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Maple Grove Care Community 215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michele Mackenzie

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To 2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_265526_0012, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The license shall protect residents from abuse and neglect by doing the following:

1. Follow the home specific bowel protocol and physician's orders for individualized bowel routines.

2. Complete and document abdominal assessments as required by the home's bowel management policy.

3. Follow residents' care plans for bowel management and constipation.

4. Monitor residents for signs and symptoms of constipation and notify physician as directed.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual Harm/risk
Scope: Isolated
Compliance history: Previously issued as a CO on July 28, 2016.

The licensee failed to ensure that resident #001 was protected from abuse by anyone and free from neglect by the licensee or staff.

Resident #001 returned to the Long Term Care home from hospital in July 2016.

The resident's Power of Attorney (POA) indicated that the resident's level of mobility declined after re-admission from the hospital. Resident #001 also had a care plan in place to prevent constipation related to decreased mobility. The care plan directed staff to follow the home's bowel protocol which was: registered staff to administer 30 millilitres (mls) of Milk of Magnesia (MOM) if the resident did not have a bowel movement (BM) for two days, then administer a glycerin suppository if no BM for three days, and if no BM for four days, administer a Fleet enema. This protocol was also ordered by the resident's physician.

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constipation. There was documentation in the progress notes on an identified date in September 2016, that the resident's physician and the Nurse Practitioner (NP) were not available and the resident's POA did not want the on -call physician to be called. The resident was scheduled for a regular medical appointment and the home decided to send the resident to their appointment with a transfer sheet and assessments and a note in the communication book to have the resident assessed at the hospital by their physician or in emergency. The resident returned back from their appointment with orders to hold a medication and reassess next week. The resident was not responding appropriately and not looking well. The NP was called and the resident was sent to the hospital. The DOC confirmed that the physician should have been notified prior to sending the resident to hospital, as the resident was showing signs and symptoms of constipation.

The resident was admitted to the hospital with a medical diagnosis and later deceased in the hospital. The DOC confirmed that the home investigated the care given to resident #001 and confirmed that the home neglected the resident by not following their bowel protocol by completing and documenting the assessments of the resident. [s. 19. (1)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

Service Area Office /
Bureau régional de services : Hamilton Service Area Office