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 prévue 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2018	2018_760527_0018	014509-18, 015279-18	Complaint

Licensee/Titulaire de permis

2063415 Ontario Limited as General Partner of 2063415 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

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

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

KATHLEEN MILLAR (527), FARAH_ KHAN (695)

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): August 10, 13, 14, 15, 16, 17, 20, 21 and 22, 2018

The Complaint inspections included:

Log #014509-18, related to continence care, nutrition & hydration; and
Log #015279-18, related to skin & wound care, continence care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Resident Relations Manager/Social Worker, the Environmental Services Manager, the Resident Assessment Instrument (RAI) Coordinator, the Scheduling Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), maintenance staff, housekeeping aides, dietary aides, the residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

9 WN(s)
6 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	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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

The licensee's policy, directed PSWs to seat the resident in the upright position for those residents who could not be transferred to a regular dining chair.

A) Resident #001 had a nutritional plan of care indicating that they had nutritional difficulties.

The nutritional plan of care identified that resident #001 was assessed by the Speech Language Pathologist (SLP) and they recommended a specific type of food and fluids and the resident was to be specifically positioned during every meal. The Registered Dietitian (RD) assessed the resident and implemented the recommendations by the SLP.

The resident was observed on a specific date and time and was not positioned as recommended for their meal.

RPN #119 and PSW #102 were interviewed individually and they acknowledged that resident #001 was required to be positioned as per the assessed recommendation for meals, as directed in the resident's plan of care.

B) Resident #003 had a nutritional plan of care indicating that they had nutritional difficulties. The resident was assessed as needing a specific mobility device and was required to be specifically positioned during meal times.

The clinical record was reviewed and the written plan of care identified that resident #003

was being monitored and was ordered a specific type of food and fluids.

The resident was observed on a specific date at meal service and the resident was not positioned upright.

PSW #116 was interviewed and was not aware that the resident had nutritional difficulties.

The Occupational Therapist (OT) #117 was interviewed and stated that they had assessed and acknowledged that the resident should be positioned as per the assessed recommendation for meals.

C) Resident #004 had a nutritional plan of care indicating that they had nutritional difficulties. The resident was assessed as needing to be specifically positioned during meal times.

The clinical record was reviewed and the written plan of care identified that resident #003 was being monitored and was ordered a specific type of food and fluids.

The resident was observed on a specific date at meal service and the resident was not positioned directed in the plan of care.

PSW #115 was interviewed and acknowledged that the resident should be specifically positioned during meals.

The OT #117 was interviewed and stated that they had not assessed the resident; however acknowledged that the resident should be specifically positioned for meals as directed in the resident's plan of care.

The licensee failed to ensure that proper techniques were used to assist residents #001, #003 and #004, with eating, including safe positioning of residents who required assistance.

This area of non-compliance was identified during the Complaint inspection log #014509-18.

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 care set out in the plan of care was provided to the resident as specified in the plan.

A) (i) Resident #001 was assessed and required two persons to assist with their activities of daily living (ADL).

The resident was observed on three specific dates in 2018. When the resident was interviewed they said that one staff helps them. When the substitute decision maker (SDM) was interviewed, they indicated that it was usually one PSW who provided care; however two PSWs would assist with ADLs.

The plan of care related to the resident's activities of daily living was reviewed. The written plan of care directed two PSWs to provide specific ADLs to the resident.

PSW #102 and #112 were interviewed individually and identified that they provided the specific ADLs on their own. Both PSWs were aware the resident required two persons, but said that the resident was able to help them and they were always busy with resident care, that not always was a second PSW available to assist with the specific ADLs.

RN #109 was interviewed on and acknowledged that resident #001 required two PSWs to provide extensive assistance for specific ADLs.

(ii) Resident #001's health status deteriorated based on their assessments on specific dates in 2018 and based on the physiotherapy assessments conducted during 2018.

The clinical record review indicated that the resident was on a specific program for one of their ADLs, which included that the staff were directed to coach and assist resident #001 with specific exercises.

The resident was observed on three specific dates and times and the staff were not observed coaching or assisting the resident with these exercises as identified in the plan of care.

The substitute decision maker (SDM) was interviewed and told the inspector that the resident was not receiving these exercises and was not aware that the staff were supposed to assist the resident. The SDM acknowledged that sometimes the resident did not want to do things but the staff needed to encourage them.

The Physiotherapist (PT) was interviewed and they indicated that the resident used to participate in group exercise and needed encouragement to participate in the exercises and walking. The PT said that they had the resident involved in other programs, which was provided by the Physiotherapy Assistant (PTA), but they had discharged the resident.

PSW #102, #112 and RPN #118, were interviewed individually and they were not aware that the resident had specific exercises and that they were expected to coach or assist the resident to do. Both PSWs told the inspector that they don't have time to do everything they were expected to do because they didn't have enough PSWs to provide the care that all residents needed.

This area of non-compliance was identified during the Complaint inspection log #014509-18.

B) The clinical record for resident #002 was reviewed, which identified that the physician ordered the resident to have their vital signs performed and they would reassess on their next visit. The clinical record identified that the vital signs were not completed as per the physician's order.

The Acting DOC was interviewed and acknowledged that the vital signs were not performed as ordered by the physician.

This area of non-compliance was identified during the Complaint Inspection, log #015279

-18.

The licensee failed to ensure that resident #001 and #002, was provided with the care 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 to 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 #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 or system instituted or otherwise put in place was:
(b) complied with.

A) Resident #002 was assessed as being at risk for falls. The resident had an unwitnessed fall on four specific dates in 2018.

The licensee's policy related to the Head Injury Routine, directed registered staff to initiate the Head Injury Routine (HIR) when a resident was suspected of sustaining a head injury and after any unwitnessed fall. The policy also directed registered staff

complete the Head Injury Routine (HIR) as per the schedule outlined or as ordered by the physician.

The clinical record was reviewed, which identified that the registered staff implemented the head injury routine (HIR) for each of the four falls the resident had; however the staff did not complete the HIR as per the schedule.

The Acting DOC was interviewed and acknowledged that the HIR was initiated for each of the resident's four unwitnessed falls, but that the registered staff did not complete the HIR as they were expected to.

This area of non-compliance was identified during the Complaint Inspection, log #015279 -18.

B) Resident #001 was assessed and placed on a specific program for two of the ADLs.

The written plan of care was reviewed and RN #121 indicated that the resident was on a specific program for their ADLs. The RN acknowledged the resident was using a specific device to assist the resident with their ADLs. The current written plan of care was reviewed, which identified the resident was to be transferred with two persons using the device.

The licensee's policy, directed the registered staff to monitor and support PSW programs on the floors, complete evaluations for residents on the specific programs regarding their progress and accurately complete the assessments.

The Physiotherapist (PT) was interviewed and told the inspector that resident #001 was assessed for transferring. The PT said that the resident was unable to tolerate a specific type of device and had to change the resident's transfer to another type of device which required two PSWs.

The ADOC #103 was interviewed and indicated that resident #001 was being transferred using a different device. The ADOC acknowledged that RN #121 completed the program evaluation on a specific date in 2018, as they worked on that unit and knew the resident. After the ADOC compared the written plan of care with the program evaluation, they acknowledged that the documentation does not reflect the changes in resident #001's transfer needs.

This area of non-compliance was identified during the Complaint inspection log #014509-18.

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

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 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, (b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

A) Resident #001's plan of care identified that they were to perform one of their ADLs using a specific type of device and staff were to check the resident frequently. The plan of care also identified that the resident was on a specific type of program, that required cueing and specific interventions at certain times throughout the day.

The clinical record was reviewed and the Point of Care (POC) documentation for a three

month period in 2018 and revealed inconsistent documentation by the PSW staff.

Both the plan of care and POC documentation was reviewed with RPN #118 and PSW #102. The PSW acknowledged that they were expected to document the resident's care in POC. Both the RPN and PSW identified that there was inconsistent documentation and said that this could be when they were short staffed and sometimes they were just so busy providing care to the residents, that documentation could be missed. Neither the RPN or PSW were able to provide any specific dates of when they were short staffed.

The licensee failed to ensure that any actions taken with respect to resident #001's continence care was documented.

This area of non-compliance was identified during a Complaint Inspection, log #014509-18.

B) Resident #002's plan of care identified that the PSWs were expected to conduct checks on each shift and if there was new or worsening skin integrity they were to report to the charge nurse. Resident #002 was admitted with altered skin integrity and continued to experience new and/or worsening altered skin integrity throughout their stay in the home.

(i) Review of the clinical record revealed that the checks by the PSWs were not documented on specific dates and times.

In addition, the PSWs had consistently documented during three months in 2018, that there was no altered skin integrity, however during this time period the resident did have altered skin integrity. During the resident's stay the PSWs had documented no altered skin integrity.

(ii) The plan of care also identified the resident was to have specific interventions for altered skin integrity. There was no documentation that the intervention was implemented on specific dates.

PSW #122 was interviewed and they said that they were expected to perform checks when they were providing care to the resident and document their findings in POC on each shift.

The Acting DOC was interviewed and acknowledged that PSWs were expected to

document their checks for resident #002 in POC and notify the charge nurse if there was anything abnormal.

(iii) Resident #002 was assessed as at risk for falls and experienced a number of falls throughout their stay in the home. The resident had a specific intervention implemented in the falls prevention plan of care to minimize injury and for safety. There was no documentation by the PSWs in Point Click Care (POC) that the intervention was implemented on specific dates and times.

The resident was also assessed to need hourly safety checks. The hourly safety checks were not documented as being performed on specific dates and times.

PSW #122 was interviewed and said that the resident had a history of falls. The PSW said that the resident was being closely monitored. The PSW acknowledged that they were expected to document in POC when they checked the resident and that the falls preventions interventions were implemented and if the resident refused care.

The Acting DOC was interviewed and acknowledged that the PSWs were expected to document in POC when they checked the resident and implemented the interventions. They were also expected to notify the charge nurse if they had any issues.

(iv) Resident #002 had an admission assessment, which identified that they required extensive assistance of two persons for activities of daily living (ADLs).

Resident #002's written plan of care identified required extensive assistance by two staff for a specific ADL. The POC review revealed that there was no documentation on specific dates and shifts by the PSWs.

In addition, the documentation on other shifts during these months were documented as mostly one person assisting the resident with their ADL.

PSW #122 was interviewed and acknowledged that resident #002 required extensive assistance of two PSWs for their care. The PSW identified that they sometimes provided the care to the resident on their own, rather than two PSWs, because they didn't always have time to get extra help as they were helping the other PSW on the unit.

RPN #137 was interviewed and acknowledged that resident #002 required two PSWs to assist them with the specific ADL.

This area of non-compliance was identified during the Complaint Inspection, log #015279 -18.

The licensee failed to ensure that any actions taken with respect to resident #001 and #002, under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

RPN #140 assessed resident #002 on admission and identified they had altered skin integrity. The RPN did not use a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The clinical record was reviewed, which identified that the assessment conducted on the resident upon admission was the incorrect assessment, as it did not provide any clinical information related to the assessment of the altered skin integrity. Further review revealed that the resident was found with a new area of altered skin integrity. On specific dates in 2018, the resident had an area of altered skin integrity and there were no assessment using the clinically appropriate tool for altered skin integrity.

The licensee's policy, directed registered staff to complete an assessment for resident's exhibiting altered skin integrity and to provide immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required.

RPN #134 and the Acting Director of Care (DOC) were interviewed individually and both acknowledged that resident #002 had altered skin integrity when admitted. They also acknowledged that RPN #140 conducted an assessment on admission using the incorrect assessment. The Acting DOC acknowledged that when the resident had altered skin integrity on three specific dates during their stay in the home, the staff were expected to use a specific assessment tool to conduct the assessments.

The licensee failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

This area of non-compliance was identified during the Complaint Inspection, log #015279 -18.

2. The licensee failed to ensure that, (b) a resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #002 was admitted with altered skin integrity in specific areas.

The clinical record was reviewed and on the Treatment Administration Record (TAR), it identified that the treatment for a specific areas was not started until several days after their admission. The documentation on the referral form did not indicate what action was taken to treat other areas of altered skin integrity.

The licensee's medical directives, directed registered staff to perform specific treatments to the areas of altered skin integrity. These treatments were not provided to resident #002 as per the Medical Directives.

The Acting DOC was interviewed and acknowledged that registered staff were expected to implement the Medical Directives for resident #002, until the resident was assessed by the specialist and/or the physician.

The licensee failed to ensure that resident #002, who was exhibiting altered skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This area of non-compliance was identified during the Complaint Inspection, log #015279 -18.

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that the resident who was incontinent and had an individual plan of care implemented to promote and manage bowel and bladder continence based on the assessment.

A) Resident #001 had a plan of care indicating that they were incontinent of bladder and were placed on a specific program.

The licensee's policy, directed all nursing staff to adhere to the resident's individualized care plan, which would include the scheduled times for checking, changing and residents.

The resident was observed on four specific dates and times. Staff were not observed cueing or offering the resident to go to the toilet.

The clinical record was reviewed and the written plan of care indicated the resident required a two person assistance. The assessment indicated the resident was to receive care as per the scheduled plan. The current written plan of care indicated that the resident was on a specific re-training program, which directed staff to cue the resident and check every two hours. The written plan of care directed staff to have the resident on a routine, to check the resident and to offer if they need to go to the toilet.

PSW #102 said that they check the resident and they could use the call bell if needed. The PSW was not aware that the resident was on a retraining program as assessed and noted in the plan of care.

The DOC was interviewed and stated that the PSWs were expected to implement the plan of care for resident #001.

The licensee failed to ensure that the individualized plan of care to promote and manage continence based on the assessment for resident #001, was implemented.

This area of non-compliance was identified during a Complaint Inspection, log #014509-18.

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, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that, (d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

Resident #002 was admitted into a specific resident room and there was no toilet seat on the toilet.

The complainant was interviewed and indicated that when resident #002 was admitted to the home, there was no toilet seat for more than two days and the Substitute Decision Maker (SDM) had to bring a chair from home. The complainant told the inspector that they had notified the nursing staff on admission and again the following day and still no toilet seat. They also lodged a complaint with the home as it was not resolved at the time.

Reviewed the home's Complaints binder, which indicated that during morning rounds it was brought to their attention by a PSW, that the SDM had concerns.

LTCH Inspector #527 reviewed the licensee's new admission checklist, which indicated that the toilet and seat were in good repair and operational.

The Maintenance requisition was reviewed and indicated that a request by RPN #124 was made requesting to fix the toilet cover and replace missing toilet seat.

The Director of Maintenance and the Administrator were interviewed individually. Both acknowledged that there was no toilet seat on the resident's toilet in their room for several days until.

The licensee failed to ensure that procedures were developed and implemented to ensure that, (d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

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 procedures are developed and implemented to ensure that, (d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

The licensee's policy directed staff to secure the call bell cords in a safe and appropriate manner within reach by resident #001 at all times.

The clinical record review was completed and the plan of care identified that the resident was able to use the call bell when they required assistance.

The resident's staff communication response system (call bell) at the bedside was observed and it was wrapped several times around the bed rail. The resident was unable to activate the call bell. LTCH Inspector #527 tried to activate the call bell system and it was non-functioning.

PSW #102 was interviewed and acknowledged that the resident will sometimes use the call bell when they need assistance. The PSW said that the call bell sometimes gets wrapped around the bed rail so it doesn't fall on the floor, but that the call bell should be clipped to the resident's blanket so that they were able to reach it and use it.

The licensee failed to ensure that the resident-staff communication response system for resident #001 was easily seen, accessed and used by residents, staff and visitors at all times.

This area of non-compliance was identified during a Complaint Inspection, log #014509-18.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents received a bath at minimum of twice weekly by the method of their choice.

A) Resident #015 informed Inspector #695 that their preference was to shower twice weekly; however instead of receiving a shower, the resident received a sponge bath.

Personal Support Worker (PSW) #111 stated that two PSWs were expected to provide the showers for the resident.

B) Resident #022 stated that they receive a shower twice weekly, as per their preference; however their shower was missed the previous week related to a staffing shortage. The resident stated that they were not offered a shower until their next shower day.

The residents plan of care stated that the resident preferred to have a shower twice weekly. A record review in Point of Care (POC) showed no shower was documented for the specific date in 2018. There was no explanation found in the progress notes.

The Executive Director was interviewed and acknowledged that it was expected that all residents receive a bath, at minimum of twice weekly, by the method of their choice.

The licensee failed to ensure that resident #015 and #022, received their preferred method of bathing, a shower, at a minimum of twice weekly.

Issued on this 7th day of November, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) :	KATHLEEN MILLAR (527), FARAH_ KHAN (695)
Inspection No. / No de l'inspection :	2018_760527_0018
Log No. / No de registre :	014509-18, 015279-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 17, 2018
Licensee / Titulaire de permis :	2063415 Ontario Limited as General Partner of 2063415 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Maple Grove Care Community 215 Sunny Meadow Boulevard, BRAMPTON, ON, L6R-3B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amy Wilkinson

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

Ministère 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:

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

Ministère 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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with s.73 (1) 10 of O. Reg 79/10.

Specifically the licensee must:

a) Ensure residents #001, #003 and #004, are positioned safely with eating, in accordance with their assessed needs in the plan of care.

b) Ensure Personal Support Workers (PSWs) and any other staff providing direct care to residents have knowledge of residents #001, #003 and #004's nutritional plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

The licensee's policy, directed PSWs to seat the resident in the upright position for those residents who could not be transferred to a regular dining chair.

A) Resident #001 had a nutritional plan of care indicating that they had nutritional difficulties.

The nutritional plan of care identified that resident #001 was assessed by the Speech Language Pathologist (SLP) and they recommended a specific type of food and fluids and the resident was to be specifically positioned during every meal. The Registered Dietitian (RD) assessed the resident and implemented the recommendations by the SLP.

The resident was observed on a specific date and time and was not positioned as recommended for their meal.

RPN #119 and PSW #102 were interviewed individually and they acknowledged that resident #001 was required to be positioned as per the assessed recommendation for meals, as directed in the resident's plan of care.

B) Resident #003 had a nutritional plan of care indicating that they had nutritional difficulties. The resident was assessed as needing a specific mobility

device and was required to be specifically positioned during meal times.

The clinical record was reviewed and the written plan of care identified that resident #003 was being monitored and was ordered a specific type of food and fluids.

The resident was observed on a specific date at meal service and the resident was not positioned upright.

PSW #116 was interviewed and was not aware that the resident had nutritional difficulties.

The Occupational Therapist (OT) #117 was interviewed and stated that they had assessed and acknowledged that the resident should be positioned as per the assessed recommendation for meals.

C) Resident #004 had a nutritional plan of care indicating that they had nutritional difficulties. The resident was assessed as needing to be specifically positioned during meal times.

The clinical record was reviewed and the written plan of care identified that resident #003 was being monitored and was ordered a specific type of food and fluids.

The resident was observed on a specific date at meal service and the resident was not positioned directed in the plan of care.

PSW #115 was interviewed and acknowledged that the resident should be specifically positioned during meals.

The OT #117 was interviewed and stated that they had not assessed the resident; however acknowledged that the resident should be specifically positioned for meals as directed in the resident's plan of care.

The licensee failed to ensure that proper techniques were used to assist residents #001, #003 and #004, with eating, including safe positioning of residents who required assistance.

This area of non-compliance was identified during the Complaint inspection log #014509-18.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 4 history of on-going non-compliance with this section of the Act that included:

- Written notification (WN) and Voluntary plan of correction (VPC) issued June 13, 2018, (2018_544527_0005)

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Central West Service Area Office