Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2019	2019_723606_0017	012486-19, 014460-19	Critical Incident System

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

JANET GROUX (606)

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 26, 30, 31, and August 1, 2019. Long Term Care Homes (LTCH) Inspector Lucia Kwok #752 took part in this inspection.

The following Critical Incident System (CIS) intakes were inspected:
Log # 012486-19 regarding misappropriation of a controlled substance and Log # 014460-19 regarding a resident who fell and sustained a serious injury.

PLEASE NOTE: A Written Notification and Compliance Order related to O. Reg. 79/10, s. 8 (1)(b) was identified in this inspection for log #014460-19 and has been issued in a concurrent Complaint inspection report # 2019_723606_0016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers (SDM) and Residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Skin and Wound Care

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

- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

A) A Critical Incident System (CIS) reported that resident #014 fell and sustained a serious injury.

The home's policy entitled, "Falls Prevention and Management", stated that each care community will have a falls prevention and management program in place to reduce the incidence of falls and the risk of injury to residents. The policy directed the registered staff to conduct a falls risk assessment within 24 hours of move in. The policy stated that all newly moved in residents were considered at high fall risk (regardless of the assessment scoring) until completion of the six-week post move in assessment. Upon completion of the detailed fall risk assessment, update the plan of care with associated risk level and interventions. The policy stated members of the interprofessional team included the registered staff, the Physiotherapist (PT), Occupational Therapist (OT) and Recreation.

Resident #014's progress notes were reviewed on identified dates and stated the resident has had a number of falls. A Fall Risk Assessment completed on an identified

date indicated the resident was at an identified risk level of falling. Their admission plan of care was initiated and stated that they were at an identified risk level for falls related to their medical condition and medical treatment. There was no evidence in the resident's plan of care to indicate that the resident was at an identified risk level of falling.

The PT stated that they had assessed resident #014 on admission and did not find the resident to be at risk of falling nor did they considered them at an identified risk level for falling. They acknowledged that they were not aware that the nursing department had deemed the resident at an identified risk level for falls on admission. Personal Support Worker (PSW) #115 and Registered Nurse (RN) #110 revealed that resident #014 was able to walk when they were admitted and did not think they were at risk of falling. They acknowledged that they did not know resident #014 was deemed at an identified risk level for falling when they were admitted.

B) Resident #017's plan of care stated that the resident was at an identified risk level for falls. However, the resident's admission plan of care did not identify that resident #017 was deemed at an identified risk of falling. Resident #017's assessments did not show evidence that a Fall Risk Assessment was completed on admission as required by the home. The Assistant Director of Care (ADOC) confirmed that a Falls Risk Assessment was not completed for resident #017 when they were admitted.

C) Resident #018 was admitted on an identified date and a Fall Risk Assessment was completed and stated the resident was at an identified risk level for falls. Resident #018's plan of care stated that the resident was at an identified risk level for falls. There was no evidence in resident #018's admission plan of care that the resident was deemed at an identified risk level of falling.

The Director of Care (DOC) stated that on admission all residents were considered at an identified risk level for falling regardless of what the Fall Risk Assessment stated. They revealed that the resident's plan of care would be updated to reflect this and that this information was shared with the other team members including other registered staff, PSWs, and the PT. They stated the the registered staff were responsible to communicate the resident's Fall Risk Assessment to the PT and revealed that the PT had access to the resident's Fall Risk Assessment in Point Click Care (PCC).

The licensee has failed to ensure that the staff and others involved in the different aspects of care for resident #014, #017, and #018 collaborated with each other in the assessment of the residents and in the development and implementation of the plans of

care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly

by a member of the registered nursing staff.

A) A CIS reported resident #014 had a fall resulting in a serious injury.

Resident #014's progress notes on an identified date stated the resident was witnessed by a staff member to fall. The resident was assessed and received an identified medical procedure. The resident had an identified skin integrity impairment as a result of the medical procedure. Review of the resident's skin integrity impairment had a treatment in place and was reassessed on a weekly basis and was still ongoing as of an identified date. Further review of the resident's progress notes stated the resident had a fall on an identified date with an identified skin integrity impairment. A treatment plan of care initiated on an identified date to the identified skin integrity impairment was in place and the treatment was discontinued after it had healed.

Resident #014's skin assessment for an identified date stated an initial skin assessment was completed for an identified skin integrity impairment. The identified skin integrity impairment was reassessed the following week. However, the resident's clinical records did not show the weekly skin re-assessment required for an identified date was completed.

B) Resident #015's clinical records stated that the resident had a fall and sustained an identified skin integrity impairment.

Resident #015's clinical records stated that a physician order was given to treat the identified skin integrity impairment with an identified treatment as required and to discontinue when healed.

Resident #015's skin assessments stated that an initial skin assessment to the identified skin integrity impairment was completed and was re-assessed on an identified date as required. However, there was no evidence that showed that the identified skin integrity impairment was reassessed after this date.There were no other weekly skin reassessments noted for the identified skin integrity impairment after an identified date.

Registered Practical Nurse (RPN) #116 and the DOC stated that when a resident has been identified with a skin integrity impairment, the skin impairment was reassessed weekly.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including

skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #012 and #014 were administered drugs that were prescribed for them.

A CIS reported resident #012's evening dose of an identified medication was missing from the package.

Review of resident #012's progress notes on an identified date indicated that the physician had ordered changes to the resident's identified medication.The pharmacy did not send the medication as ordered by the physician. As such, RPN #119 borrowed the identified medication prescribed to another resident and administered this medication to resident #012.

The progress notes for resident #014 on an identified date revealed the resident's identified medication was not received from the pharmacy. RPN #118 went to the home's emergency medication supply and when there was none available they then borrowed the identified medication from resident #020 and administered this medication to resident #014.

The ADOC confirmed that the identified medication was borrowed from resident #020 and was administered to resident #014.

The DOC stated that when an identified medication was ordered by a physician was missing or wasted, the pharmacy should be contacted for special delivery and should not borrowed from another resident.

The licensee failed to administer medication as ordered for residents #012 and #014. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 10th day of September, 2019

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

Original report signed by the inspector.