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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 28, Jul 18, 2017	2017_566669_0009	009453-17	Resident Quality Inspection

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

MAPLE MANOR NURSING HOME
73 BIDWELL STREET TILLSONBURG ON N4G 3T8

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

ANDREA DIMENNA (669), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 24, 25, 26, 29, 30 and 31, 2017.

The following critical incidents were completed with this inspection:
#1049-000006-16/019425-16, related to falls prevention
#1049-000009-16/019935-16, related to an injury that resulted in transfer to hospital
#1049-000018-16/034195-16, related to falls prevention
#1049-000013-16/026810-16, related to falls prevention.

The following complaint was completed with this inspection:
IL-46771-LO/027814-16, related to falls prevention.

During the course of the inspection, the inspector(s) spoke with 20+ residents, two representatives of Residents' Council, Administrator, Director of Care (DOC), Nurse Practitioner (NP), Resident Assessment Instrument (RAI) Coordinator, three Registered Nurses (RNs), six Registered Practical Nurses (RPNs), and 10 Personal Support Workers (PSWs).

During the course of the inspection, the Inspectors conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspectors observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

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

- **4 WN(s)**
- **4 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Record review of the plan of care for the resident revealed an intervention was required at all times when the resident was in a mobility device due to safety risks. The plan of care included a specific safety intervention and to document the use of the intervention in Point of Care (POC).

During an interview, a PSW stated that the resident used this intervention and that documentation would be completed in POC, which would include that the specific intervention was provided.

One month of records on POC for the resident were reviewed and revealed there was missing documentation: the use of the intervention was not recorded on 27 out of 28 days (96%) on the day shift and 22 out of 28 days (79%) on the evening shift.

In an interview, DOC acknowledged that documentation was missing on POC for the specific intervention and that it was the home's expectation that documentation on tasks should be completed.

The severity was determined to be a level one as there minimum risk. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 9, 2015, as a VPC in a RQI and on January 19, 2016, as a VPC in a RQI. [s. 6. (9) 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 the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10 s. 48 (1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

The resident was admitted to the home on a specific date, and a review of the resident's clinical record showed that the resident fell on six different dates.

The home's current falls policy, "Falls Prevention and Management Program, NDM-III-400," dated March 7, 2011, stated that a care conference was to be arranged for residents who fall frequently as indicated by: two falls in 72 hours; more than three falls in three months; more than five falls in six months.

Record review showed no care conferences arranged for the resident related to frequent falls. During an interview, DOC was unable to reproduce documentation of a care conference and stated no care conference had occurred.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 9, 2015, as a CO in a RQI (complied with on February 4, 2016) and on January 19, 2016, as a VPC in a RQI. [s. 8. (1) (a),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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's current falls policy, "Falls Prevention and Management Program, NDM-III-400," dated March 7, 2011, stated that registered nursing staff complete a Post Fall Screen for Resident/Environmental Factors (Appendix D), review the fall prevention interventions and modify the plan of care in collaboration with the interdisciplinary team. DOC clarified that the Post Fall Screen for Resident/Environmental Factors referred to the home's current Post-Fall Assessment Form, and that the policy needed to be revised to reflect accurate terminology.

Review of three Critical Incident Reports identified concerns related to post-falls assessments.

a) One resident's clinical record was reviewed and showed that the resident fell on a

specific date and sustained multiple injuries.
b) Another resident's clinical record was reviewed and showed that the resident fell on a specific date and sustained an injury.
c) A third resident's clinical record was reviewed and showed that the resident fell on two specific dates and sustained an injury on both occasions.

A documentation review was conducted and Post-Fall Assessment Forms could not be located for any of the aforementioned falls.

Two RPNs were interviewed and stated that their role following a fall would be to assess the resident, and complete documentation, including a post-fall assessment. One of the RPNs and an RN who was also interviewed indicated that post-fall assessments were documented on the Post-Fall Assessment Form, located on the unit in the falls binder.

DOC was interviewed and said that the home's Post-Fall Assessment Form was a clinically appropriate tool to document post-fall assessment, and that it was the home's expectation that staff fill out the Post-Fall Assessment Form after every fall. DOC clarified that a progress note did not qualify as a clinically appropriate tool to document a post-fall assessment. DOC stated that post-fall assessments could not be located for any of the three residents' falls outlined above.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in this subsection of the legislation. [s. 49. (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 when a resident falls, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action were taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

The home's policy, "Medication Incident Reporting" - 14.7, stated the following:
"a) All medication incidents and adverse drug reactions are reviewed and analyzed;
b) Corrective action is taken as necessary: and
c) A written record is kept of everything required under clauses a) and b)."

Record review of the medication incident reports for a three-month period was completed, noting nine incidents in total. Two incidents reviewed did not document corrective actions nor follow-up with the employees involved.

An RPN was interviewed and shared that management did not follow up with them related to the medication incident reports on two specific dates involving two residents.

The RPN remembered the medication incidents, but stated that management did not follow up and the RPN received no instruction related to corrective action to prevent reoccurrence. During an interview, DOC shared that the follow-up with staff would be completed by the DOC but that it would not be documented on the medication incident reports or in the staff file; DOC stated that this was usually done verbally and the follow-up provided was not recorded. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything provided for in clause (a) and (b).

The home's policy, "Medication Incident Reporting" - 14.7, stated:
"During the quarterly review at the Pharmacy and Therapeutics or Professional Advisory Committee meeting, the Director of Nursing and Personal Care [DOC] should report all medication incidents, including a brief statistical analysis of the types of incidents, their severity level, and their outcome. After discussing the compiled results, changes and/or improvements should be discussed among committee members, in an effort to reduce the frequency of future medication incidents or adverse drug reactions. The Consultant Pharmacist provides current guidelines on the Medication Incident reporting and Adverse Drug Reaction reporting process in the home, in accordance with all applicable legislation and best practice guidelines. Once identified changes or improvements are agreed upon, these recommendations are implemented by the committee, and such changes are monitored within the Home and are discussed at the next quarterly Pharmacy and Therapeutics or Profession Advisory Committee meeting."

During an interview, DOC stated that the home reviewed the medication incidents that were submitted, and generally summarized the reports on a monthly basis to include information such as identifying the incidents related to root cause (eg, transcription, omission, wrong dose, wrong medication, wrong resident). DOC shared that this had not yet been done for any of the submitted 2017 medication incidents. DOC stated that medication incidents were not reviewed at the Pharmacy and Therapeutics or Professional Advisory Committee meetings in order to reduce and prevent medication incidents and adverse drug reactions, or to identify any changes and improvements required.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this subsection of the legislation. [s. 135. (3)]

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 medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

Issued on this 25th day of July, 2017

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

Original report signed by the inspector.