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 le Loi de 2007 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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Bureau régional de services de London
130 avenue Dufferin 4ème étage
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2018;	2018_607523_0013 (A1)	012564-18, 013391-18	Critical Incident System

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Amended by ALI NASSER (523) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

No Amendment completed on the public reports.

Issued on this 12 day of July 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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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
Jul 12, 2018;	2018_607523_0013 (A1)	012564-18, 013391-18	Critical Incident System

Licensee/Titulaire de permis

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73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Amended by ALI NASSER (523) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 11, 12 and 13, 2018.

This inspection was conducted for:

Critical Incident intake Log #012564-18, CIS #1049-000015-18 related to unexpected death of a resident.

Complaint intake Log #013391-18, related to unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Maintenance Worker, Outside Contractor, six registered staff and three Personal support workers.

The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Reporting and Complaints

Safe and Secure Home

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

2 WN(s)
0 VPC(s)
2 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much details as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

The home submitted a Critical Incident System (CIS) report on a certain date related to an unexpected death of a resident. The CIS report showed that on a certain date a staff member found the resident unresponsive in their room. Vital signs were absent.

The Administrator said in an interview that on the date on incident they were called by the night RPN and informed of the incident and the unexpected death of the resident.

The Administrator said that they did not call the after hour's pager to inform the Director of the incident. The Administrator said that they should have called to inform the Director immediately of the unexpected death of resident. [s. 107. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The home submitted Critical Incident System (CIS) report on a certain date related to an unexpected death of a resident.

A review of the home’s policy #NDM-III-420, Subject: Resident Bedrail Risk Assessment for Entrapment, date April, 20, 2015, included the following:
Responsibility: Registered Staff, Director of Care: Bed Rail Risk Assessment must be completed by registered staff on: Admission, Quarterly (with RAI-MDS), change to existing rails, change in condition of Mattress due to wear and compression.
If bed rails were required, registered nursing staff are responsible for: side rails must be securely fastened to the bed frame according to the manufacture’s direction.
Bed System Testing: The maintenance Supervisor or approved service provider will test the entrapment zones using the approved bed system testing device on: Admission (within 72 hours), placement of new mattress, upon identified concerns from staff or once every 2 years.

Clinical record review and staff interviewed showed that the Bed Rail Risk Assessment was completed for the resident upon admission.
The DOC said in an interview that the homes expectations, policy and best practice directed staff to complete the Bed Rail Risk Assessment on admission, return from hospital, quarterly or anytime there was changes to the bed.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 12 day of July 2018 (A1)

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

Original report signed by the inspector.

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by ALI NASSER (523) - (A1)
Inspection No. / No de l'inspection :	2018_607523_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012564-18, 013391-18 (A1)
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 12, 2018;(A1)
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Maple Manor Nursing Home 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marlene Van Ham

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

To Maplewood Nursing Home Limited, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Order / Ordre :

The licensee must be compliant with s.107(1)(2).
Specifically the licensee must ensure that the Director is immediately informed, in as much details as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

Grounds / Motifs :

(A1)
1. Finding: r. 107. (1)
Inspector: 523
The licensee has failed to ensure that the Director was immediately informed, in as much details as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

The home submitted a Critical Incident System (CIS) report #1049-000015-18, on June 11, 2018 at 0931 hours related to an unexpected death of a resident. The CIS report showed that on June 10, 2018 at 2150 hours a staff member found the resident with their body lying on the floor and their neck and head wedged against the assist railing. Vital signs were absent.

On June 11, 2018, PSW #101 said in an interview that on June 10, 2018 at around 2130 hours they responded to an alarm from resident #001's room. They found the resident with their neck and head lodged in the assist rail and their body was laying on the fall mat on the left side of the bed. PSW #101 called the resident's name three times but resident was not responsive, they informed RN #111 and the RN assessed resident and found vital signs absent. The RN then called 911.

On June 11, 2018, RN-RAI Coordinator #100 said in an interview that on June 10, 2018 at around 2300 hours they got a call from an RPN informing them of the incident and the unexpected death of the resident. RN #100 informed the RPN that they were not on call and directed them to call the Administrator and inform them of the incident. RN #100 said that they submitted the CIS on June 11, 2018.

On June 13, 2018, Administrator #102 said in an interview that on June 10, 2018 at around 2300 they were called by the night RPN informing them of the incident and the unexpected death of the resident, they asked if it was ok for the RN-RAI to complete the CIS in the morning, Administrator #102 said it was ok.

Administrator #102 said that they did not call the after hour's pager to inform the Director of the incident. Administrator #102 said that they should have called to inform the Director of the unexpected death of resident #001.

The severity of this issue was determined to be a level 2, minimal harm/risk or potential actual harm/risk. The scope of the issue was a level 1 as it was isolated. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
Written Notification and Voluntary Plan of Correction issued on March 5, 2018 (2018_678680_0005).
Written Notification and Voluntary Plan of Correction issued on March 24, 2016 (2016_277538_0003).

(523)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Aug 31, 2018

Order # / Ordre no : 002 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with s.15(1)(a).
Specifically the licensee must:
(a) Ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.
(b) Ensure that all registered staff are trained to assess residents and evaluate their bed system in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The home submitted Critical Incident System (CIS) report on a certain date related to an unexpected death of a resident.

A review of the home's policy #NDM-III-420, Subject: Resident Bedrail Risk Assessment for Entrapment, date April, 20, 2015, included the following:
Responsibility: Registered Staff, Director of Care: Bed Rail Risk Assessment must be completed by registered staff on: Admission, Quarterly (with RAI-MDS), change to existing rails, change in condition of Mattress due to wear and compression.
If bed rails were required, registered nursing staff are responsible for: side rails must be securely fastened to the bed frame according to the manufacture's direction.
Bed System Testing: The maintenance Supervisor or approved service provider will test the entrapment zones using the approved bed system testing device on: Admission (within 72 hours), placement of new mattress, upon identified concerns from staff or once every 2 years.

Clinical record review and staff interviewed showed that the Bed Rail Risk Assessment was completed for the resident upon admission.
The DOC said in an interview that the homes expectations, policy and best practice directed staff to complete the Bed Rail Risk Assessment on admission, return from hospital, quarterly or anytime there was changes to the bed.

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level as it was isolated. The home had a level 3 history as they had a previous noncompliance with this section of the LTCHA that included: Written Notification and Compliance Order issued on March 16, 2015 (2015_261522_0005) (523)

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

Jul 31, 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
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 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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	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 12 day of July 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by ALI NASSER - (A1)

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

Service Area Office / Bureau régional de services : London