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
Oct 22, 2019	2019_674610_0031	017290-19	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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 30, October 1, 2019

This Critical Incident #1049-000010-19 Log #017290-19 was completed related to Falls Prevention and Management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurse(s), Registered Practical Nurses (RPN), and Personal Support Worker(s).

The Inspectors also observed residents and the care provided to them, reviewed clinical records and plans of care for the identified residents and reviewed the homes relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 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 following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care.3. The effectiveness of the plan of care.

A) This inspection was completed related to Critical Incident (CI) received to the Ministry Long Term Care (MLTC) by the home. The CI report showed that a resident had a fall and was transferred to the hospital with an injury.

The licensee policy "Charting Daily Graphic Records", stated in part that the expectation of the home was that staff would complete all documentation before leaving the home.

A review of the resident's plan of care showed that the resident was a high risk for falls. Interventions were created for safety around resident's high falls risk to decrease the risk of injury.

Further review of the home's internal investigation related to the resident's fall incident and record review did not indicate if the interventions that were part of the plan of care had been implemented.

A review of documentation showed that from a specific period staff had not documented for the use of interventions that were to be implemented for falls management for the resident.

B) Another Resident of the home was part of the expansion for findings of noncompliance related to fall's prevention and management. The was also identified as being high risk for falls according to the plan of care.

A review of the resident's plan of care showed interventions had been created for safety around resident's high falls risk to decrease the risk of injury.

A review of documentation showed that from a specific period staff had not documented for the use of interventions that were to be implemented for falls management for the resident.

C) A third Resident was part of the expansion for findings of noncompliance related to fall's prevention and management. The Resident was also identified as being high risk for falls according to the plan of care.

A review of the resident's plan of care showed the interventions had been created for safety around the resident's high falls risk to decrease the risk of injury.

A review of documentation showed that from a specific period staff had not documented for the use of interventions that were to be implemented for falls management for the resident.

During an interview a Personal Support Worker (PSW) said that they could not recall the last time they had falls prevention management training. They also verified that they don't always complete all the documentation in POC and that if the current plan of care was to leave the resident bed in the lowest position that they leave the bed in a high position to deter a specific resident from trying to get into the bed alone.

The DOC verified that they had issues in the pass with staff not documenting the care provided and that this was an issue as they required accuracy and compliance for the generation of the Resident Assessment Instrument (RAI) that drives the resident care in the home for care planning.

The DOC further verified that they had an in-service on where all PSW staff had received educated related to POC, RAI, and other items such as assistance of daily living levels tasks.

The DOC also said that the expectation of staff was to have all documentation of resident care completed prior to staff leaving the home as care that was not documented was considered not completed.

The licensee has failed to ensure that the following were documented for the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care for the resident's.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The license has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

This inspection was completed related to Critical Incident (CI) received to the Ministry of Health Long Term Care (MOHLTC) by the home. The CI report showed that the resident had a fall and was transferred to the hospital with an injury.

The homes policy "Critical Incident and Unusual Occurrence Reporting", stated in part that critical incident reports shall be completed on-line for improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm to residents.

During a review of documentation for the resident, there was an incident note that had identified an injury to the resident from a staff member of the home. The same member had assessed the resident and noted the injury. A nurse completed an assessment and documented the injury.

The resident had a fall, was transferred to the hospital and diagnosed with an injury.

The home's internal investigation notes showed that the Administrator was informed of the incident on the same day the incident had occurred.
A consultation had been completed at the hospital for the resident and showed that the resident has an injury related to the incident with the staff member. The home was made aware of the incident on the same day.

During an interview the DOC said that they were aware of the incident but had been on holidays at the time of the incident. Though the Administrator was aware of the incident that had occurred to resident and they failed to report the incident to the Director. The DOC also stated that they provided education to all the registered staff in the fiscal year of 2018 for reporting certain matters to the Director, however in this incident the RN and the Administrator failed to report the incident.

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 person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

Issued on this 22nd day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2019_674610_0031
Log No. / No de registre :	017290-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 22, 2019
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

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

Specifically, the licensee must:

1. Ensure that all staff providing personal support services in the home receive training related to a Personal Support Worker's role for documentation requirements after providing care to resident's.
2. Ensure that all staff providing nursing and personal support services in the home receive training related to the home's policy and process for documentation for the provision, outcome, and effectiveness of the care set out in the plan of care.
3. A written record is kept of all training related to documentation and plan of care, including staff names, dates and training type.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care.3. The effectiveness of the plan of care.

A) This inspection was completed related to Critical Incident (CI) received to the Ministry Long Term Care (MLTC) by the home. The CI report showed that a resident had a fall and was transferred to the hospital with an injury.

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The licensee has failed to ensure that they had documented for the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care for the resident's.

The severity of this issue was determined to be a level 2 as there was minimal risk. The scope of the issue was a level 3 as it was widespread and had the potential to affect other resident's in the home. The home had a compliance level of 3 as they had a history with this section of the LTCHA that included: Written Notification (WN), and Voluntary Plan of Correction (VPC) issued on July 18, 2017, Inspection #2017_566669_0009. (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 10, 2019

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 22nd day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Moroney

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