Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Aug 25, 2020	2020_778563_0022	001821-20, 004147-20, 004791-20, 012139-20	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

MELANIE NORTHEY (563), AYESHA SARATHY (741)

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): August 11, 12 and 13, 2020

The following Follow-Up was also completed at the time of this inspection:
Log #001821-20 for Compliance Order #001 from inspection #2020_797740_0001 related to s. 6. (9) with a Compliance Due Date of February 28, 2020.

The following Critical Incident (CI) intakes were completed within this inspection:
Log #004147-20 / CI 1049-000007-20 related to falls prevention and management.
Log #004791-20 / CI 1049-000008-20 related to falls prevention and management.
Log #012139-20 / CI 1049-000011-20 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Practical Nurses, a Registered Nurse, Physiotherapy Assistants, Personal Support Workers and residents.

The Inspectors also made observations of residents and care provided. Relevant policies and procedures, education records, as well as clinical records and plans of care for identified residents were reviewed.

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (9)	CO #001	2020_797740_0001	563

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care related to safety interventions to resident #003.

The Critical Incident System (CIS) Report documented an incident for which the resident was taken to hospital and resulted in a significant change in their health status.

The current "Restraint/Safety Devices" care plan for the resident documented the discontinuation of specific fall interventions.

The resident was observed, and the specific fall interventions that were documented as discontinued from the care plan were not in place. However, the Resident Care Guide posted above the resident's toilet in their bathroom documented that the fall interventions were still in use.

During an interview with the Personal Support Worker (PSW) they stated they were familiar with the resident. The PSW stated the resident no longer used the specific fall interventions.

The Director of Care (DOC) stated it was the responsibility of the registered nursing staff, Physiotherapist and the Registered Dietitian to update the resident care plans and the Resident Care Guides posted in resident rooms. The DOC verified that for the use of alarms, the plan of care was updated to include the discontinuation of specific fall interventions. The DOC then verified that in a different section of the resident’s care plan

the fall interventions were still in use. The DOC stated the entire plan of care required updating to reflect that the use of the specific fall interventions were discontinued. The Inspector showed the DOC a picture of the Resident Care Guide posted in the resident's bathroom. The Resident Care Guide documented with a check that specific fall interventions were in use. The DOC acknowledged that the plan of care did not set out clear directions to staff and others who provided direct care to the resident.

An observation of the Resident Care Guide, the next day, posted in the resident's bathroom remained unchanged and identified the specific fall interventions were still checked as in use for the resident.

The Registered Nurse (RN) stated whoever updated the care plan would also be responsible for updating the Resident Care Guides posted in the residents' bathrooms. The RN stated the interventions should have been removed from both sections of the care plan and removed from the Resident Care Guide when the specific interventions were discontinued.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The Critical Incident System (CIS) Report documented a fall incident for which the resident was taken to hospital and resulted in a significant change in their health status.

The current care plan for the resident #001 documented specific interventions related to toileting assistance.

The resident was observed in their room and at that time, the Resident Care Guide posted in the bathroom cabinet stated the resident required a specific level of care for toileting.

The resident was interviewed and verified that the level of care related to toileting did not match the level of care documented as part of the Resident Care Guide.

The Director of Care (DOC) stated the resident required staff assistance for toileting. The Inspector showed the DOC a picture of the Resident Care Guide posted in the resident’s

bathroom and the DOC acknowledged that the plan of care related to toileting assistance did not set out clear directions to staff and others who provided direct toileting care.

The Registered Practical Nurse (RPN) stated Physiotherapy updates the transfer status on the Resident Care Guides and the Registered Nurse was responsible for updating the care plan. The RPN stated it was the responsibility of the person updating the care plan to also update the Resident Care Guide.

The Registered Nurse (RN) stated whoever updated the care plan would also be responsible for updating the Resident Care Guides posted in the residents' bathrooms. The RN stated the process for updating a resident’s plan of care included revising the care plan in Point Click Care, documenting a progress note that a change in the care plan was made and the Resident Care Guide would be updated.

An observation of the Resident Care Guide, the next day, posted in the resident’s bathroom remained unchanged and stated the resident was independent for toileting.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care related to toileting and staff assistance to the resident. [s. 6. (1) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 25th day of August, 2020

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

Original report signed by the inspector.