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

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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
Mar 8, 2022	2022_834524_0006	017204-21, 003646-22	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

INA REYNOLDS (524), TATIANA PYPER (733564)

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): March 2 and 3, 2022.

The following Critical Incident System (CIS) intakes were completed within this inspection:
CIS # 1049-000011-21 / Log # 017204-21 related to falls prevention and management

CIS # 1049-000001-22 / Log # 003626-22 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, a Registered Nurse, a Registered Practical Nurse, Personal Support Workers, a Physiotherapist Assistant, a Housekeeping Aide and residents.

The inspector(s) also observed resident rooms and common areas, infection prevention and control practices within the home, residents and the care provided to them, reviewed clinical healthcare records and plans of care for identified residents, and relevant policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within three business days after the occurrence of an incident that caused an injury to a resident, resulting in a significant change in the resident's health condition, and a transfer to hospital.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC). The report indicated that a resident had an unwitnessed fall on a specific date and was transferred to the hospital the next day for assessment.

The resident progress notes on Point Click Care (PCC) showed that on a specific date, a registered staff and a physiotherapist had documented that the resident had an injury that resulted in a significant change in their health condition.

The home's Critical Incident/Unusual Occurrence Reporting policy stated that "when critical incidents occur, the incident is to be reported to the MOHLTC according to the reporting requirements."

The Acting Director of Care acknowledged that the home did not report the incident within three business days after the occurrence of the resident's fall incident.

Sources: Critical Incident Report System (CIS), the resident's clinical records, the home's policy titled "Critical Incident/Unusual Occurrence" (Revision Date: November 2018), and interview with the Acting Director of Care. [s. 107. (3.1)]

Issued on this 8th day of March, 2022

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

Original report signed by the inspector.