Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: July 13, 2023

Inspection Number: 2023-1028-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Maplewood Nursing Home Limited

Long Term Care Home and City: Maple Manor Nursing Home, Tillsonburg

Lead Inspector	**Inspector Digital Signature**
Julie Lampman (522)	Julie Lampman Digitally signed by Julie Lampman Date: 2023.07.14 14:27:45 -04'00'

Additional Inspector(s)
Kristen Murray (731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 30, and 31, 2023 and June 1, 2, 5, 6, 7, 8, 12, 13, and 14, 2023.

The following intake(s) were inspected:

- Intake: #00017288 - Critical Incident System (CIS) report #1049-000001-23 related to falls prevention and management
- Intake: #00019926 - CIS #1049-000002-23 related to a medication incident
- Intake: #00087204 - 1049-000005-23 related to the failure/breakdown of the home's communication and response system
- Intake: #00088407 - CIS #1049-000006-23 related to falls prevention
- Intake: #00089284 - CIS #1049-000007-23 related to responsive behaviours
- Intake: #00088343 - Complainant related to resident care
- Intake: #00019467 - Complaint related to resident care.

The following intake(s) were completed in this inspection:

- Intake: #00017288 - CIS #1049-000001-23 related to falls prevention and management

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Pain Management
Palliative Care
Resident Care and Support Services
Responsive Behaviours
Safe and Secure Home
Skin and Wound Prevention and Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident's altered skin integrity so that their assessments were integrated, were consistent with and complemented each other.

Rationale and Summary
A resident developed an area of altered skin integrity which worsened. The resident's skin and wound assessments noted the resident had three areas of altered skin integrity in the same location. A number of assessments that were required for these areas of altered skin integrity were missing.

A registered staff member stated the resident only had one area of altered skin integrity. The registered staff member reviewed the resident's skin and wound assessments and stated they were of the same area of altered skin integrity and staff were documenting under the wrong assessments and should have only documented under the first assessment.

The Director of Care (DOC) stated registered staff should have consistently documented under one area of altered skin integrity and closed the other two open assessments.

There was minimal risk to the resident as the resident did have weekly skin and wound assessments completed for the area of altered skin integrity.

Sources:
Review of the resident's clinical records and interviews with staff. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

A) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) regarding care provided to a resident. The resident had specific care directives that their family had requested that were to be put in place immediately if the resident had a change in condition.

A registered staff member stated they responded to the resident's change in condition and called the Nurse Practitioner to inform them. The registered staff member stated they then called two of the resident's family members for direction. The registered staff member acknowledged that the resident's care directive was not initiated until they spoke with the resident's family.

Although the outcome may not have changed, there was risk to the resident by not initiating their care directive immediately.

Sources:
Review of the resident's clinical records and interviews with staff. [522]

B) The licensee has failed to ensure that the care set out in the plan of care for another resident was provided to the resident as specified in the plan.

Rationale and Summary

The MLTC received a complaint related to oral care concerns for a resident. The resident's plan of care stated that they were to have their teeth cleaned at specific times of day.

The resident stated to Inspector #731 that they did not have their teeth cleaned at a specific time. An unregistered staff member stated that the resident did not have their teeth cleaned at that time.

The home's "Dental and Oral Care" policy stated that after each meal, a resident's teeth and/or mouth were supposed to have been cleaned with a toothbrush or mouth swab.

The Director of Care (DOC) stated that staff should have been following the plan of care for providing oral care to the resident.

There was risk to the resident related to their mouth care not being provided as specified in their plan of care.

Sources: The home's "Dental and Oral Care" policy NDM-IIII-247 dated April 19, 2017; the resident's clinical records, including care plan and care records; and interviews with the resident and staff. [731]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

A) The licensee has failed to ensure that hourly checks set out in the plan of care for residents on a specific floor were documented.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) regarding the breakdown of the home's communication and response system.

The call bell system in resident rooms and bathrooms on a specific floor was lighting but did not alarm. Residents were given tapping bells to alert staff if they needed assistance. Staff were to complete intentional rounding/checks on residents every hour to check if residents had pain, required positioning, possessions or their personal needs taken care of.

An unregistered staff member stated they had to document hourly that they had checked to see if residents needed anything and had their tapping bells within reach.

Review of the Maple Manor Nursing Home Hourly Checks for the home area for a one week period, noted documented checks were missing for different shifts in the East, Centre, North and South hallways. On one day, there was no documentation of hourly checks.

A registered staff member reviewed the hourly checks with Inspector #522 and confirmed the missing documentation. The registered staff member stated that staff should be documenting each hour that they had checked on the residents in their home area.

There was no risk to residents by staff not documenting hourly checks.

Sources:
Review of CIS #1049-000005-23, Maple Manor Nursing Home Hourly Checks, Intentional Comfort Rounds posters, and interviews with staff. [522]

B) The licensee has failed to ensure that the provision of care set out in the plan of care for four residents was documented.

Rationale and Summary
The MLTC received a complaint related to evening care concerns for multiple residents, including personal hygiene and oral care. Four residents required extensive assistance for some areas of evening care. Personal hygiene and oral care were not documented as provided for any of the four residents on one evening. During a one month period, on seven out of thirteen days, evening care including oral care and personal hygiene was documented as completed before 1600 hours, for two residents. On eight out of thirteen days, oral care and personal hygiene care was documented as completed before 1600 hours, during the evening shift for the other two residents.

An unregistered staff member stated they documented resident care before the care was provided to the residents.

The home's evening care routine process stated that during the last round of the evening shift, at approximately 2100 hours, residents should have oral care provided and documentation for care should have been completed.

The Director of Care (DOC) stated that care for residents should have been documented after the care was provided to residents.

There was risk to the residents related to their oral care and personal hygiene care not being

documented after it was provided to the residents.

Sources: The home's HS Care routine; resident's clinical records, including care plan and care records; and interviews with staff. [731]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.

The licensee has failed to ensure that the plan of care for a resident was based on an interdisciplinary assessment of pain with respect to the resident.

Rationale and Summary
A resident had complaints of new pain. The resident continued to have pain over the following couple weeks and at that time was identified to have a possible injury. The resident had no plan of care initiated related to pain management, goals, and intervention, when they were exhibiting new pain.

The home's "Pain Management" policy stated that registered staff were supposed to initiate a plan of care related to pain management for each resident.

The Assistant Director of Care (ADOC) stated that the resident should have had a pain section, including interventions, in their plan of care.

There was risk to the resident related to pain management goals and interventions not included in the resident's plan of care.

Sources: The home's "Pain Management" policy NDM-III-410 dated October 2, 2018; the resident's clinical records, including progress notes, plan of care, and assessments; and interviews with staff. [731]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a

resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Head Injury" policy NDM-III-235 dated April 19, 2017.

Rationale and Summary
The home's "Head Injury" policy stated where a head injury was sustained, a head injury routine (HIR) should be initiated and continued for a 24 hour period. Registered staff were to monitor and record vital signs, pupils and hand grips every 60 minutes for the first four hours. Close observation was to be paid to the resident's level of consciousness, speech, mental alertness, abnormal tremors in limbs, and movement of extremities.

An unregistered staff member reported to a registered staff member that a resident hit their head.

Review of the resident's HIR noted that it had not been completed in full.

The registered staff member acknowledged they did not complete the HIR as required. The registered staff member stated for most residents they would complete the HIR as required, but they let the resident sleep because they were very restless.

The staff's failure to follow the home's "Head Injury Routine" policy placed the resident at moderate risk, as staff had the potential to miss possible injuries if regular assessments were not completed.

Sources:
Review of the resident's clinical record, the home's "Head Injury" policy NDM-III-235 dated April 19, 2017, and interviews with staff. [522]

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee has failed to comply with the home's skin care and wound management policy related to

effective interventions included in the required skin and wound care program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the skin and wound care program and ensure they were complied with.

Specifically, staff did not comply with the home's "Skin and Wound Care Directives" dated January 2023, and "Skin Care And Wound Management Program" policy NDM-lll-239, dated April 19, 2017.

Rationale and Summary
The home's "Skin and Wound Care Directives" noted in part that the mainstay of healing certain types of altered skin integrity was pressure relief. If these types of altered skin integrity were discovered staff were to advocate for use of a pressure relieving surface for these residents.

The home's "Skin Care and Wound Management Program" policy stated that registered staff should ensure that residents with certain areas of altered skin integrity were provided with a pressure relief therapeutic surface.

A resident had developed an area of altered skin integrity. The Nurse Practitioner recommended that the resident have a pressure relieving surface.

Observations of the resident noted that the resident did not have a pressure relieving surface.

An unregistered staff member stated that the resident still had an area of altered skin integrity. The staff stated that the resident would benefit from a pressure relieving surface and that they had asked for one for the resident.

A registered staff member stated usually residents with certain areas of altered skin integrity would have a pressure relieving surface as an intervention.

The Director of Care (DOC) stated they did not know why the resident did not have a pressure relieving surface and contacted staff to ensure that the resident was given a pressure relieving surface.

There was moderate risk to the resident by not having a pressure relieving surface.

Sources:
Review of the resident's clinical record, the home's "Skin and Wound Care Directives" dated January

2023, and “Skin Care And Wound Management Program” policy NDM-lll-239, dated April 19, 2017, and interviews with staff. [522]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was completed using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
A resident sustained a fall, and a post-fall assessment was not completed in Point Click Care (PCC) for the resident.

The home’s "Falls Prevention and Management" policy stated that when a resident had fallen, the resident would be assessed, including the specifics of the fall and outcomes.

The Administrator stated that a post-fall assessment was not completed for the fall that the resident sustained and should have been.

There was risk to the resident related to the post-fall assessment not being completed after their fall.

Sources: The home’s "Fall Prevention and Management" policy NDM-IIII-400 dated March 7, 2011; the resident's clinical records, including progress notes and assessments; and an interview with the Administrator. [731]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

A) The licensee has failed to ensure that a resident, who had an area of altered skin integrity, was assessed by a Registered Dietitian (RD) who was a member of the staff of the home.

Rationale and Summary
The Ministry of Long-Term Care received an anonymous complaint related to the care provided to a

resident.

The resident had developed an area of altered skin integrity, that had deteriorated, and was not referred to the RD.

A registered staff member reviewed the resident's clinical record and acknowledged a referral to the RD had not been made. The registered staff member stated a referral should have been sent to the RD regarding the resident's area of altered skin integrity as that was part of the home's protocol.

There was moderate risk to the resident as they had a deteriorating area of altered skin integrity and had not been seen by the RD when the area developed.

Sources:
Review of the resident's clinical record, the home's "Skin Care And Wound Management Program" policy NDM-lll-239, dated April 19, 2017, and interviews with staff. [522]

B) The licensee has failed to ensure that when another resident was exhibiting altered skin integrity, they were assessed by a RD.

Rationale and Summary
A resident had developed several new areas of altered skin integrity over a two month period. The resident was not referred to the RD related to any of the new areas of altered skin integrity.

The home's "Skin Care and Wound Management" policy stated that registered staff were to make referrals to the interdisciplinary team members, including the RD as required, and the RD was to complete a nutrition assessment.

The Assistant Director of Care (ADOC) stated that a resident was supposed to be referred to the RD for any new or worsening area of altered skin integrity. The ADOC stated there were no referrals for the RD related to any of the new areas of altered skin integrity.

There was increased risk to the resident related to not being assessed by the Registered Dietitian when they developed new areas of altered skin integrity.

Sources: The home's "Skin Care and Wound Management" policy NDM-IIII-239 dated April 19, 2017; the resident's clinical records, including progress notes and assessments; and an interview with the ADOC. [731]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that when a resident was exhibiting altered skin integrity, they were reassessed at least weekly.

Rationale and Summary
A resident had several areas of altered skin integrity assessed. Weekly skin assessments were not completed consistently for each area of altered skin integrity.

The home's "Skin Care and Wound Management" policy stated that registered staff were to ensure that the resident was reassessed weekly.

The Assistant Director of Care (ADOC) stated that areas of altered skin integrity should have been monitored at least weekly and some of the resident's weekly assessments were not completed.

There was risk to the resident related to their areas of altered skin integrity not being reassessed at least weekly.

Sources: The home's "Skin Care and Wound Management" policy NDM-IIII-239 dated April 19, 2017; the resident's clinical records, including progress notes and assessments; and an interview with the ADOC. [731]

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument.

Rationale and Summary
A resident had complaints of new pain. The resident continued to have pain and as needed (PRN) medication was identified to be ineffective at times. A pain assessment was not completed for the resident when they were exhibiting new pain that was not relieved by initial interventions.

The home's "Pain Management" policy stated that registered staff were supposed to have conducted a pain assessment using a clinically appropriate instrument when resident exhibited pain that was not relieved by initial interventions.

The Assistant Director of Care (ADOC) stated a pain assessment should have been completed for the resident when they were first experiencing new pain, and a pain tool should have been completed for five days.

There was risk to the resident related to not having a pain assessment completed.

Sources: The home's "Pain Management" policy NDM-III-410 dated October 2, 2018; the resident's clinical records, including progress notes, eMAR and assessments; and interviews with the ADOC. [731]

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of the unexpected or sudden death of a resident.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care regarding the passing of a resident.

A registered staff member indicated on the Resident Death Notice that the resident's death was unanticipated given the resident's medical condition and medical trajectory.

A unregistered staff member and two registered staff members all provided care to the resident and stated their death was sudden and unexpected.

There were no Critical Incident System (CIS) report submissions related to the unexpected or sudden death of the resident.

The Director of Care (DOC) stated they did not submit a CIS report as they felt the resident's death was expected due to the resident's diagnosis and health history.

Sources:
Review of the resident's clinical records, Long Term Care Homes.net and interviews with staff. [522]

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.

The licensee has failed to ensure that the Director was informed no later than one business day of a breakdown of the home's communication and response system.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care regarding the breakdown of the home's communication and response system, that had occurred six days earlier.

The Administrator acknowledged the CIS report was submitted late.

There was no risk to residents due to late reporting the breakdown of the communication and response system to the Director.

Sources:
Review of CIS report #1049-000005-23, and interviews with the Administrator and other staff. [522]

WRITTEN NOTIFICATION: Administration of Drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident was administered five times the dose of an ordered medication and required medical treatment.

A registered staff member stated that when they asked another registered staff member to show them how much medication they had administered to the resident, they noted that they had administered the

wrong dosage.

There was moderate impact to the resident when they received five times the prescribed dose of medication.

Sources:
Review of Critical Incident System report #1049-000002-23, the resident's clinical records, a medication incident report and interviews with staff. [522]

WRITTEN NOTIFICATION: Training and Orientation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (1)

The licensee has failed to ensure that the training and orientation program for the home was implemented to provide the training and orientation required under section 82 of the Act.

Rationale and Summary
A complaint was received by the Ministry of Long Term Care (MLTC) related to agency staff members in the home not receiving training prior to providing care to residents.

An unregistered staff member stated they did not complete surge learning training prior to starting to work on the units within the home. The long-term care home's training records identified that the staff had not completed their required training, including resident's bill of rights, prevention of abuse and neglect, infection prevention and control (IPAC), heat-related illness, behavioural supports Ontario (BSO), restraints, and continence care training.

The Director of Care (DOC) stated that agency staff were supposed to have completed surge learning prior to starting their orientation shifts on the units. The DOC and the Administrator stated that the staff member had not completed their required training on surge learning.

There was increased risk related to the staff member not having completed their training prior to providing care to residents.

Sources: Complaint submitted to the MLTC; the home's training records; and interviews with the DOC, and the Administrator. [731]