Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 11, 2024
Inspection Number: 2024-1028-0001
Inspection Type: Critical Incident
Licensee: Maplewood Nursing Home Limited
Long Term Care Home and City: Maple Manor Nursing Home, Tillsonburg

Lead Inspector	**Inspector Digital Signature**
Julie Lampman (522)	
Additional Inspector(s) Pauline Waldon (741071)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3, 4, and 5, 2024.

The following intake(s) were inspected:

- Intake: #00098361/Critical Incident System (CIS) report related to a change in resident condition;
- Intake: #00104890/CIS related to a change in resident condition;
- Intake: #00102444/CIS related to falls prevention and management.

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

- Intake: #00096037/CIS and Intake: #00097274/CIS related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that a resident's personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

Rationale and Summary
Inspectors #522 and #741071 observed an open and unattended electronic

Medication Administration Record (eMAR) screen with resident PHI visible in a resident home area. At that time, a visitor was pushing a resident past the eMAR screen. Approximately one minute later, a registered staff member came out of a resident room and returned to the eMAR screen.

The registered staff member acknowledged they had not closed the resident's eMAR and that they would normal close the eMAR screen when they left the medication cart unattended.

There was risk of a breech of a resident's PHI when staff left the eMAR screen open with PHI visible in the hallway with visitors and residents present.

Sources:
Observations during the inspection and an interview with a registered staff member and other 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 (9) 1.
Plan of care
Documentation
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.

The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care regarding a resident who had a change in condition.

Registered Nurse (RN) #108 stated they had been asked to assess the resident when they had a change in condition. RN #108 stated when they reviewed documentation of the resident's intake that afternoon they were unable to determine if the resident had eaten their meal on the previous shift as documentation had not been completed for the that meal.

Personal Support Worker (PSW) #109 stated PSWs were to document the percentage of meals and snacks a resident ate or drank and report to registered staff if a resident had less than 50 per cent of their meal; this was not completed.

Sources:
Review of a CIS report, a resident's clinical record, and interviews with PSW #109, RN #108 and other staff. [522]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from neglect by a registered staff member.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Rationale and Summary:
A resident had a fall with no injuries noted at the time of the initial post fall assessment.

Later that evening, a Personal Support Worker had reported signs of an injury, the resident was assessed and signs indicating an injury were noted. It wasn't until the next morning that the resident was again assessed to have signs and symptoms of an injury that the resident was sent for medical treatment.

The home’s investigation notes stated that the registered staff member decided to monitor the resident and not send the resident for medical treatment or call the on-call physician because the resident did not show signs and symptoms of pain, acknowledging that this decision delayed further care.

The DOC reported that they had expected the registered staff member to call the physician on-call and to send the resident for medical treatment when they presented with signs of an injury.

The DOC further reported that the registered staff member created a risk of harm to the resident through improper care of the resident. The registered staff member was to complete additional falls training as a result.

Failing to provide the resident with the care required when they presented with

signs of an injury, resulted in delayed treatment.

Sources:
The resident's progress notes, the home's investigation notes and interview with the DOC. [741071]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that when a resident fell, that Head Injury Routine (HIR) monitoring was completed as required.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the homes Falls Prevention and Management Program policy.

Rationale and Summary:
The home's Falls Prevention and Management Program policy stated that a HIR was

to be completed for all unwitnessed falls. Furthermore, the Director of Care (DOC) reported that staff were expected to restart the HIR in the event a resident had a subsequent unwitnessed fall.

Unwitnessed falls for a resident were documented in progress notes on four occasions in a one month period. On two occasions there was no HIR completed.

On two other occasions, it was documented that HIR's were not restarted because the resident was already on HIR monitoring for prior falls.

By not completing the HIR's as required, had the resident experienced signs and symptoms of a head injury post fall, there was risk that they would have gone unnoticed.

Sources:
The resident's progress notes and HIR Neurological Records, Falls Prevention and Management Policy, (NDM-III-400) and interview with the DOC. [741071]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

Rationale and Summary
Inspectors #522 and #741071 observed an unlocked and unattended medication cart in a resident home area. At that time, a visitor was pushing a resident past the unlocked medication cart. Approximately one minute later, a registered staff member came out of a resident room.

The registered staff member acknowledged they had not locked the medication cart and that it should have been locked when it was unattended.

Sources:
Observations during the inspection, review of Roulston Pharmacy's "The Safe Storage of Medications" policy #5.0, and interviews with the registered staff member and other staff. [522]

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. 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 had a change in condition. The registered staff member called the Nurse

Practitioner (NP) who informed the registered staff member due to the resident's change in condition and as per the medical directives and a specific home protocol the resident needed to be given a specific medication right away. The NP also gave a verbal order for the medication and for the resident to seek medical attention. Registered staff did not administer the medication as ordered, stating the resident was seeking medical attention.

RN #103 stated a stat order for a resident should be administered prior to a resident seeking medical attention.

The Director of Care (DOC) stated staff did not follow the home's protocol and should have administered the medication to the resident prior to the resident seeking medical attention.

Registered Staff not following the resident's medical directives and NP orders delayed the resident in receiving appropriate treatment for their change in condition.

Sources:
Review of a CIS report, the resident's clinical record, a specific home protocol, and interviews with RN #103, the DOC and other staff. [522]

WRITTEN NOTIFICATION: Retraining

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (3) (b)
Retraining
s. 260 (3) For the purposes of subsection 82 (6) of the Act,
(b) the further training needs identified by the assessments shall be addressed in the manner the licensee considers appropriate.

The licensee has failed to ensure that a registered staff member completed retraining in falls prevention and management as required.

Rationale and Summary:
The home's investigation notes stated that the registered staff member was required to complete retraining in falls prevention and management for failing to provide a resident with proper care when the resident presented with signs of a an injury.

The DOC acknowledged that the staff member did not complete the additional retraining as required.

There was risk that the registered staff member would not follow the home's policies and procedures because they did not complete the retraining as required.

Sources:
The home's investigation notes and interview with the DOC. [741071]