Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2017	2017_700536_0017	023971-17	Resident Quality Inspection

Licensee/Titulaire de permis

1365853 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée

MAPLE PARK LODGE
6 Hagey Avenue Fort Erie ON L2A 5M5

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

CATHIE ROBITAILLE (536), CATHY FEDIASH (214), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 19 and 20, 2017.

The following inspections were completed concurrently with the Resident Quality (RQI) Inspection.

Complaint

Intake #022546-17 pertaining to: responsive behaviours

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, Director of Therapeutic Recreation, Environmental Supervisor, Director of Care (DOC) and the Administrator.

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to: staffing schedules, policies and procedures, meeting minutes, clinical health records and complaint log reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Legendé 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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home's "Medication Incident Report" forms between two identified dates in 2017, indicated the following:

A) On an identified date in 2017, resident #009 received the medications prescribed for resident #010 at a specified medication pass. The Director of Care (DOC) indicted that the incident had been reported to the pharmacy service provider; however, the portion of

the Medication Incident Report which was to be completed by pharmacy, was blank. The DOC confirmed that no documentation was able to be provided that this incident was reported to the pharmacy service provider.

B) On an identified date in 2017, resident # 010 received the medications prescribed for resident #009 at a specified medication pass. The DOC indicated that the incident had been reported to the pharmacy service provider; however, the portion of the Medication Incident Report which was to be completed by pharmacy, was blank. The DOC confirmed that no documentation was able to be provided that this incident was reported to the pharmacy service provider.

C) On an identified date in 2017, resident #007, was administered a specified medication at an identified time. Registered Staff #115 discovered that this medication should not have been administered. A review of the Medication Incident Report including resident #007's clinical record, had not identified the immediate actions taken to assess and maintain the resident's health. A review of the resident's "vitals tab" in Point Click Care (PCC) indicated that a blood pressure had been documented and entered with a time, which was approximately eight hours after becoming aware of the medication incident report.

An interview with the DOC on October 20, 2017, confirmed that every medication incident involving a resident and every adverse drug reaction had not been documented with a record of the immediate actions taken to assess and maintain the resident's health and had not been reported to the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record was kept of everything provided for in clauses (a) and (b).

During an interview with the DOC and registered staff #103 on October 20, 2017, documentation was provided of the home's quarterly review of all medication incidents since the time of the last review. A review of documentation from August 2016 to June 2017, indicated that quarterly, a list of the types of medication errors had been documented; however, no further documentation was included to identify a review of these incidents or any changes and improvements. At the bottom of this document was

a table that identified areas to document the date of the concern; the details of the concern; the plan for improvements; the person responsible for improvements; the date the improvement plan was to be implemented; the quality indicator to measure success and the evaluation of outcomes. This table was blank and contained no documentation under these headings.

An interview with the DOC confirmed that a quarterly review of all medication incidents in the home including any changes or improvements since the last time of the last review in order to reduce and prevent medication incidents had not been completed. [s. 135. (3)]

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 and ensuring that any medication error involving a resident and every adverse drug reaction is reported to and follow up completed by the pharmacy service provider as per the home's medication incident report, as well as a quarterly review is undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record was kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs changed, or when care set out in the plan of care was no longer necessary.

On October 18 2017, a review was completed of resident #004's plan of care which the home refers to as the care plan. On an identified date, the care plan was updated and identified that the resident was to receive a specified treatment. A progress noted on another identified date and time, stated the following: treatment ended, Care Plan updated. Registered staff #103 confirmed that resident #004's care plan had not been reviewed and revised as indicated in the progress note, when the treatment was completed and the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept locked and closed.

On October 16 and 17, 2017, the service elevator door was observed to be unlocked on an identifed home area. Interview with Personal Support Worker (PSW) #105 acknowledged that the door was unlocked and identified that the elevator was used only by the laundry department. They indicated that they did not have a key to lock the door; however, they notified the appropriate staff member. Housekeeper #106 acknowledged that the home's expectation was that the service elevator doors should be locked, as a resident could get into the unlocked elevator and the door could be closed. The housekeeper also confirmed that the unlocked door had then been locked, and was no longer a concern.

Interview with the Environmental Supervisor on October 19, 2017, confirmed that the home's expectation was that the service elevators, used solely by the laundry department, were to be locked at all times. They indicated that the unlocked door was a safety risk, as residents could open the door and enter the elevator, and may be unable to exit. The home did not ensure that doors that residents have access to were kept locked and closed. [s. 9. (1) 1. i.]

Issued on this 2nd day of November, 2017

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

Original report signed by the inspector.