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 prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Feb 1, 2019	2019_575214_0002	012765-18, 022015-18, 000916-19	Critical Incident System

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

CATHY FEDIASH (214), KELLY CHUCKRY (611)

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): January 10, 11, 14, 15, 16, 17, 18, 21, 22, 23 and 24, 2019.

Please note: This CIS inspection was conducted simultaneously with complaint inspection #2019_575214_0001 / 002894-18, 023239-18, 026276-18, 027810-18.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care; Nursing Clinical Support staff; Nursing Department clerk; Registered staff; Personal Support Workers and residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions and the provision of care; reviewed resident clinical records; relevant policies and procedures; the home's internal investigative notes and staff training records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

- **3 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of Critical Incident Submission (CIS) #2891-000001-19, log #000916-19, indicated that on an identified date, resident #003 alleged that a staff member had provided care to them, in a specified manner.

Long term care (LTC) homes Inspector's conducted an interview with resident #003 on an identified date in relation to a separate inspection. During this interview, resident #003 provided a specified description of the manner of care they had received. The resident verbalized their care concerns and the level of assistance required for a specified activity of daily living. This information was immediately reported to the DOC by the Inspector's.

A review of the resident's current, electronic care plan in place at the time of this inspection, indicated under a specified activity of daily living (ADL) that the resident was capable of using an identified device with two staff.

During an interview with the Administrator and the DOC on an identified date and time, the DOC confirmed that the resident was required to have two staff present to provide the identified ADL and that care set out in resident #003's plan of care, had not been provided as specified in their plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A) A review of CIS #2891-000001-19, log #000916-19, indicated that on an identified date, resident #003 alleged that a staff member had provided care to them, in a specified manner.

Long term care (LTC) homes Inspector's conducted an interview with resident #003 on an identified date. During this interview, resident #003 provided a specified description of the manner of care they had received. The resident verbalized their care concerns and the level of assistance required for a specified activity of daily living. This information was immediately reported to the DOC who confirmed that they had not been made aware of this information prior.

A review of the resident's clinical records indicated that a progress note dated with an identified date and time, had been documented and indicated that the resident reported to staff #120 that their care on a specified shift had been provided in a specified manner and that they had not wanted the staff member to provide care to them again.

A review of the licensee's policy, titled, "Abuse-Prevention, Reporting and Elimination of Abuse and Neglect" (CA-05-37-1 and dated May 2016) indicated the following:

a) Staff and volunteers who witness abuse or suspect the abuse or neglect of a resident or who receive complaints of abuse/neglect should report the matter immediately to the Administrator (or designate).

During an interview with the Administrator and the DOC on an identified date and time, the DOC confirmed the resident's progress note identified above and that the allegation

had not been reported to the Registered nurse or management immediately. The DOC confirmed that the licensee's abuse policy had not been complied with in relation to this allegation of abuse toward resident #003.

B) A review of CIS #2891-000012-18, log #022015-18, indicated that on an identified date, resident #001 was in a specified location in the long term care home with an identified person. A staff member had approached to assist the resident with an identified task and observed specified actions of the identified person towards the resident. The identified person was then observed to have demonstrated a different specified action toward the resident. The staff member removed the resident from the area and the resident verbalized an identified comment.

An interview with the Administrator on an identified date and time, indicated that staff had notified them four days later regarding concerns involving the identified person. A review of progress notes and an interview with the Administrator on an identified date and time, indicated that staff observed the identified person two days prior, to have demonstrated a specified action toward the resident. The Administrator indicated that at this time, they began to look into everything and reported the incident on an identified date and time.

A review of the licensee's policy, titled, "Abuse-Prevention, Reporting and Elimination of Abuse and Neglect" (CA-05-37-1 and dated May 2016) indicated the following:

a) Staff and volunteers who witness abuse or suspect the abuse or neglect of a resident or who receive complaints of abuse/neglect should report the matter immediately to the Administrator (or designate).

During the interview with the Administrator on an identified date and time, they confirmed that the above incident had not been reported immediately and that the licensee's abuse policy had not been complied with. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of CIS #2891-000012-18, log #022015-18, indicated that on an identified date, resident #001 was in a specified location in the long term care home with an identified person. A staff member had approached to assist the resident with an identified task and observed specified actions of the identified person towards the resident. The identified person was then observed to have demonstrated a different specified action toward the resident. The staff member removed the resident from the area and the resident verbalized an identified comment.

A review of the resident's progress notes for a specified period of time, indicated that the incident on an identified date, including any assessments; interventions put into place or the resident's response to any interventions, had not been documented in the resident's clinical record.

An interview with the Administrator on an identified date and time, confirmed that no documentation had been recorded in the resident's clinical record regarding the identified incident, including any assessments; interventions put into place or the resident's response to any interventions. [s. 30. (2)]

Issued on this 12th day of February, 2019

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

Original report signed by the inspector.