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

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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_0001	002894-18, 023239-18, 026276-18, 027810-18	Complaint

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 Complaint 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 Complaint inspection was conducted simultaneously with Critical Incident System inspection #2019_575214_0002 / 012765-18, 022015-18, 000916-19.

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 (PSW), residents and complainants.

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; complaint logs and staff training records.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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).

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

During complaint inspections, Log #023239-18, and Log #027810-18, the clinical health records for resident #004 was reviewed.

The written plan of care for resident #004 with an identified date of revision, indicated that this resident had a preference regarding a specified activity of daily living (ADL). This preference was over any other alternatives available. Review of the PSW documentation records for an identified period of time, indicated that resident #004 received their identified preference only once and all other times, the specified ADL was provided in an alternative form.

On an identified date, interviews took place with staff #139, #143, and #149. All three staff confirmed that resident #004 received the specified ADL in an alternative form, the majority of the time.

During an interview with the DOC on an identified date, it was confirmed that the care provided to resident #004 was not provided as specified in their plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident 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 change or care set out in the plan was no longer necessary.

During complaint inspections, Log #023239-18, and Log #027810-18, the clinical health records for resident #004 was reviewed. The written plan of care for resident #004, with an identified date of revision, indicated that this resident had an identified apparatus in place. It further indicated that the resident had a specified person who was the only person to manage the identified apparatus.

During an interview with staff #139 on an identified date, it was confirmed that the specified person for resident #004 would provide identified actions to manage the apparatus for this resident on an identified basis. It was further confirmed that the specified person had been unable to manage the apparatus for a while due to identified reasons. Staff assigned to provide care to resident #004 did not provide specified tasks to manage the residents apparatus, in the absence of the specified person.

During an interview with staff #149 on an identified date, it was confirmed that resident #004's specified person had been unable to manage the apparatus for a while.

During an interview with staff #143 on an identified date, it was confirmed that the specified person was the only person allowed to touch the resident's identified apparatus. It was further acknowledged that the specified person had been unable to manage the apparatus for a while and that staff had not completed the identified tasks in the absence of the specified person.

During an interview with the DOC on an identified date, it was acknowledged that the specified person for resident #004 had been unable to manage the apparatus for a while. In a subsequent interview on the same day, the Administrator and the DOC confirmed that resident #004 was not reassessed and the plan of care was not reviewed and revised when this residents identified health care needs changed. [s. 6. (10) (b)]

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 resident is 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 change or care set out in the plan is no longer necessary, 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 review of complaint inspection, log #026276-18, indicated a concern that during an interaction with resident #001, a staff member was alleged to have demonstrated identified actions towards the resident.

During an interview with the complainant on an identified date and time, the complainant confirmed that they had observed staff #140 to have demonstrated identified actions toward the resident. The complainant indicated that this occurred on an identified date.

The complainant indicated that they had not reported their observations to the DOC until the following day due to identified reasons.

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) Page nine of this abuse policy indicated that any person who witnesses a resident being abused is obligated to report it at once to the Registered staff. Registered staff must contact the Administrator or his/her designate immediately for direction on sanctions to be imposed and for direction on how to proceed with the investigation of any alleged, suspected or witnessed abuse or neglect.

b) Page eleven of this abuse policy indicated that 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).

c) Page twelve of this abuse policy indicated that abused resident will be offered counseling and support services from management and/or staff.

During an interview with the DOC on an identified date and time, they confirmed that they had not been made aware of this allegation of abuse until the following day, when the complainant had informed them. The DOC confirmed that the licensee's abuse policy had not been complied with.

During an interview with the Administrator on an identified date and time, they confirmed that counseling and support services had not been offered to resident #001 by the management and/or staff 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.

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.