Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 1, 2019	2019_575214_0028	012938-19, 013600-19, 017599-19	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), GILLIAN HUNTER (130)

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): August 29, 30, September 3, 4, 5, 6, 10, 11, 2019.

This inspection was conducted simultaneously with complaint inspection #2019_575214_0027 / 005722-19, 011770-19, 016713-19.

The following intakes were completed during this Critical Incident System (CIS) inspection:

012938-19 - related to prevention of abuse and neglect and responsive behaviours.

013600-19 - related to falls prevention.

017599-19 - related to prevention of abuse and neglect and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Nursing Unit Clerk; Behavioural Supports Ontario (BSO) staff; registered staff; Personal Support Workers (PSW); residents and families.

During the course of the inspection, the inspector(s) reviewed CIS reports; resident clinical records; policies and procedures; staff training records; program evaluations and observed residents during the provision of care.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 and #110 were protected from abuse by resident #006.

Clinical records indicated that resident #006 was admitted to the home on an identified date with a specified diagnoses.

The plan of care, dated with a specified date, indicated the resident had a history of identified responsive behaviours. DOC #109 confirmed that a specified intervention was initiated for resident #006 on a particular date as other interventions to manage the behaviour had not been ineffective.

A) A review of resident #006's progress notes indicated that on a specified date and time, staff #102 and #103, observed resident #006 and resident #003 in a particular activity. A second incident occurred later the same day; resident #006 blocked an identified door with resident #003 in the room. Staff entered and removed resident #003, who demonstrated for staff an identified action that resident #006 had done. A third incident occurred later the same day; resident #003 was observed in an identified location with resident #006, in a specified manner and resident #006 performing an identified action.

Two days later, resident #006 was observed and was heard telling resident #003 to come to an identified location for a specified reason. Later the same day, resident #003 and #006 were observed in an identified activity.

The DOC confirmed in an interview that resident #003 was not protected from abuse by resident #006.

B) On an identified date and time, front line staff found resident #110, laying in an identified location, calling for help. Resident #006 was standing beside them. Resident #110, was removed from the room and verbalized specified concerns to the staff.

Resident #110's plan of care indicated, specified diagnoses.

The DOC confirmed that resident #110 was not protected from abuse by resident #006. [s. 19. (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 residents are protected by abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, 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 has failed to ensure that the written policy titled, Abuse - Prevention, Reporting and Elimination of Abuse and Neglect, CA-05-37-1, that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled, Abuse - Prevention, Reporting and Elimination of Abuse and Neglect, CA-05-37-1, outlined the following measures required to be taken when abuse/neglect was alleged, suspected or witnessed.

-Registered staff must contact the Administrator or his/her designate immediately.
-All incidents of alleged, suspected or witnessed abuse or neglect must be investigated.
-Registered staff will initiate an investigation report identifying all persons involved in the incident.
-The Administrator or designate must notify Ministry of Health and Long Term Care (MOHLTC) by phone immediately.
-Administrator and/or designate shall notify the resident's family members, substitute decision makers or others specified in the resident's plan of care.
-Where physical or sexual abuse has occurred or is suspected, the attending physician is

to be contacted to arrange a medical assessment.

A) On a specified date and time, staff #102 and #103, observed resident #006 and resident #003 in a particular activity. A second incident occurred later the same day; resident #006 blocked an identified door with resident #003 in the room. Staff entered and removed resident #003, who demonstrated for staff an identified action that resident #006 had done. A third incident occurred later the same day; resident #003 was observed in an identified location with resident #006, in a specified manner and resident #006 performing an identified action.

Clinical record review revealed that staff #102 and #103 reported the first incident to RN #122. RN #122 confirmed in an interview that they did not notify the substitute decision maker (SDM) of resident #003 or resident #006, the Administrator or the physician regarding the incidents, nor did they complete an investigation report.

The second and third incidents were not documented in the clinical record of resident #003. There was no record that the SDM's, Administrator, police or physician were notified of the second incident. A review of the risk management records confirmed there was no investigation reports completed for any of the incidents on a specified date.

Two days later, resident #006 was observed and was heard telling resident #003 to come to an identified location for a specified reason. Later the same day, resident #003 and #006 were observed in an identified activity.

RN #118 confirmed in an interview that they did not report the incidents to the SDM of resident #003 and resident #006; nor did they report the incidents to the Administrator, police nor the physician.

This information was confirmed by the DOC.

B) On an identified date and time, front line staff found resident #110, laying in an identified location, calling for help. Resident #006 was standing beside them. Resident #110, was removed from the room and verbalized specified concerns to the staff.

A review of the risk management records and interview with the DOC confirmed there was no investigation report completed for this incident. The DOC confirmed that the home's policy for Abuse - Prevention, Reporting and Elimination of Abuse and Neglect, 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A) The licensee has failed to ensure that abuse of resident #003 by resident #006 was immediately reported to the Director.

On a specified date and time, staff #102 and #103, observed resident #006 and resident #003 in a particular activity. The incident was reported to RN #122. A second incident occurred later the same day; resident #006 blocked an identified door with resident #003 in the room. Staff entered and removed resident #003, who demonstrated for staff an identified action that resident #006 had done. The incident was reported to RN #123. A third incident occurred later the same day; resident #003 was observed in an identified location with resident #006, in a specified manner and resident #006 performing an identified action. This incident was reported to RN #123.

Two days later, resident #006 was observed and was heard telling resident #003 to come to an identified location for a specified reason. Later the same day, resident #003 and #006 were observed in an identified activity. These incidents were reported to RN #118.

The DOC confirmed the identified incidents were not reported to the Administrator nor to the Director as required.

B) The licensee has failed to ensure that abuse of resident #110, by resident #006 was immediately reported to the Director.

On an identified date and time, front line staff found resident #110, laying in an identified location, calling for help. Resident #006 was standing beside them. Resident #110, was removed from the room and verbalized specified concerns to the staff.

The DOC confirmed they were informed of the incident and had not reported it to the Director as required. [s. 24. (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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: 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. A) The licensee has failed to ensure that any actions taken with respect to resident #003 under a program, including assessments, interventions and the resident's responses to interventions were documented.

On a specified date and time, resident #006 blocked an identified door with resident #003 in the room. Staff entered and removed resident #003, who demonstrated for staff an identified action that resident #006 had done. A second incident occurred later the same day; resident #003 was observed in an identified location with resident #006, in a specified manner and resident #006 performing an identified action.

The DOC confirmed in an interview that the incidents were not documented in the clinical record of resident #003.

B) The licensee has failed to ensure that any actions taken with respect to resident #007 under a program, including assessments, interventions and the resident's responses to interventions were documented.

On an identified date and time, resident #006 was observed and was heard telling resident #003 to come to an identified location for a specified reason. Later the same day, resident #003 and #006 were observed in an identified activity.

On an identified date, RN #118 documented that resident #006 had demonstrated an identified action with resident #007. Later the same day, resident #007 was observed in a different, identified activity with resident #006.

RN #118 confirmed in an interview, the incidents were not documented in resident #007's clinical record. This information was also confirmed by the DOC. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 1st day of October, 2019

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

Original report signed by the inspector.