Ontario

Ministry of Long-Term Care / Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007 / Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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 20, 2020	2020_794749_0004	017976-19, 019643-19	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

AMY PAGE (749), KEARA CRONIN (759)

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): February 10 to 13, 2020.

The following intakes were inspected during this Critical Incident (CI) Inspection:
-One intake related to resident to resident abuse; and
-One intake related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nursing Clinical Support (NCS), Recreation Therapist (RT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

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

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

A Critical Incident (CI) report was submitted to the Director as a result of an alleged resident to resident abuse that occurred on a specific date.

Inspector #759 reviewed the CI report, which indicated that resident #001 was in resident #002's room where a specific incident occurred. Inspector #759 was not able to identify the results of the investigation in the CI report.

Inspector #759 reviewed resident #001's electronic health records and identified a progress note written by RN #102 on a specific date, which indicated that resident #001 was found in resident #002's room, where a specific incident occurred. The progress note further indicated that resident #002 was redirected out of the room to a common area of the unit.

Inspector #759 reviewed the policy titled "Abuse-Prevention, Reporting, and Elimination of Abuse and Neglect" dated May 2016, which indicated that the findings of the investigation and corrective action taken must be submitted to the Ministry of Long-Term Care within 10 days.

2. Inspector #759 reviewed the CI report that was submitted to the Director on a specific date, where a recreation aide found resident #007 by resident #006 and a specific incident was witnessed. Inspector #759 was not able to identify the results of the investigation in the CI report.

3. Inspector #759 reviewed the CI report that was submitted to the Director on a specific date, which indicated that there were incidents of alleged abuse between resident #002 and #009. Inspector #759 was unable to identify the results of the investigation in the CI report.

During an interview with Inspector #759, the Administrator indicated that the DOC would have investigated the incidents. The Administrator confirmed to Inspector #759 that the results of each of the investigations were not reported to the Director. [s. 23. (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 ensuring that a report to the Director with the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b) is, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to resident #003 unless the drug had been prescribed for the resident.

A CI report was submitted to the Director on a specific date, in regards to an incident that involved resident #003 being administered medications that were not prescribed to them, which lead to resident #003 being transferred to hospital for treatment.

Inspector #749 reviewed resident #003’s electronic progress notes which indicated on a specific date, RN #105 was notified by RPN #106 that resident #003 had received medications that were not prescribed to them. The RN assessed resident #003. Resident #003 was sent to hospital for further treatment.

Inspector #749 reviewed resident #003’s paper medical record and identified documentation from a health care facility, which indicated resident #003 was administered medications that were not prescribed to them.

Inspector #749 reviewed the home’s one-page policy titled “Medication Administration”, last revised April 1, 2019. Under the heading “Procedure – Step two” it stated “Follow the eight rights when administering medication – right resident, right medication, right reason, right dose, right route, right frequency, right time, right site".

During interviews with RPN #101, RPN #106 and RN #105, they all indicated to Inspector #749 that the process for checking medication prior to administering them to a resident was to compare the medication pouch with the medication administration record (MAR) to verify the correct resident, medication, reason, dose, route, frequency, time and site. Then the registered staff were to verify they had the correct resident prior to administering the medication.

During an interview with RPN #101 and RN #105 they confirmed to Inspector #749 that resident #003 received medications on a specific date that were not prescribed to them, which led to resident #003 being transported to hospital for treatment.

Inspector #749 interviewed the Administrator, who confirmed registered staff were to follow the home’s medication administration policy and that on a specific date, resident #003 was administrated medications by a staff member that was not prescribed for them. [s. 131. (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 ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident is, to be implemented voluntarily.

Issued on this 20th day of February, 2020

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

Original report signed by the inspector.