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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 3, 2014	2014_188168_0003	H-000119-14	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

LISA VINK (168), CATHY FEDIASH (214), CYNTHIA DITOMASSO (528), GILLIAN TRACEY (130), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 27, 28, 29, 30, and 31, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food and Nutrition Manager (FNM), Registered Dietician (RD), Resident Assessment Instrument (RAI) Coordinator, Housekeeping Supervisor, Special Project Nurse, registered nursing staff, personal support workers (PSW), dietary aides, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical health records, meeting minutes and policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. The plan of care for resident #249, dated December 18, 2013, indicated "no infection present" however the same document also noted the use of an antibiotic twice a day for one week. Interview with registered staff confirmed the plan of care did not provide clear direction regarding the infection status of the resident.
B. The plan of care for resident #292 did not provide clear direction to staff.
i) The plan indicated that a specified cream was to be applied to the resident's knee four times a day. It also noted that the same cream was to be applied to the knee three times a day. The DOC confirmed that the plan of care did not provide clear direction regarding the treatment cream.
ii) The plan of care indicated that the resident had no pain or discomfort and that there were times when the pain experienced was horrible or excruciating. The RAI Coordinator confirmed that the written plan did not provide clear direction regarding the residents pain. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #292 had a physician's order dated November 19, 2013, for a treatment cream to be applied three times a day. Interview with registered staff confirmed that the application of the cream was to be four times a day, not the three times as ordered. Staff did not apply the treatment as specified in the plan. [s. 6. (7)]

3. The licensee did not 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 changed.

In 2014, resident #275 sustained an injury and as a result had a change in status. The current plan of care, dated December 22, 2013, indicated that the resident would attain the ability to walk in their room, ambulate unassisted, be fully dependent without devices and wander in supervised areas. An interview with the DOC confirmed that the plan was not revised with changes in care needs for mobility and assistive devices. [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 is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee did not ensure that no resident was restrained by the use of a physical device, other than in accordance with section 31.

A. On January 27, 2014, residents #001, #275 and #282 were observed in their wheelchairs with seat belt restraints fastened loosely, allowing at least a five finger width between the resident's abdomen and the device. The manufacturer application instructions, provided by the home, indicated "The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient". Registered staff confirmed the devices should only allow one hand width between the abdomen and the device.
B. On January 27, and 29, 2014, resident #282 was observed with a side fastening seat belt, while in the wheelchair. The clinical record included a consent from the Power of Attorney (POA) for a reverse fastening seat belt restraint, the restraint assessment and plan of care indicated a reverse fastening seat belt was required. Registered staff confirmed the resident was not restrained in accordance with the consent obtained, completed assessment and the plan of care. [s. 30. (1) 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 to ensure that no resident is restrained by the use of a physical device, other than in accordance with section 31, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

Interview with the active Residents' Council Representative and the FNM confirmed that the dining and snack service did not include a review of the meal and snack times by the Residents' Council or the Food Committee. [s. 73. (1) 2.]

2. The licensee did not ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to the residents.

During interviews, three residents, identified that at times the food served was either too hot or too cold.
i) On January 29, 2014, during the lunch meal service, on the Robin Parkway home area, food temperatures were probed at the completion of the meal service. The temperatures were recorded as: macaroni and cheese at 120 degrees Fahrenheit (F), carrots at 120 degrees F, fish at 120 degrees F, french fries at 110 degrees F and cheese sauce at 120 degrees F. The dietary aide and the FNM confirmed that these temperatures were not warm enough according to the homes procedures.
ii) Food temperature logs for lunch meal services on January 27, 28, and 29, 2014, were reviewed. The documents were noted to be incomplete for some menu items, however the temperature of some food items were recorded as being either too warm or too cool according to the established procedures, as confirmed by the FNM.
iii) Food Committee Meeting Minutes, dated November 25, 2013, included a concern "that sometimes the vegetables are cold". [s. 73. (1) 6.]

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 dining and snack service includes food and fluids served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Not every resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

Interviews with residents #303 and #302 identified that they felt that staff did not respect their privacy, when they would knock on their closed bedroom door and then proceed to enter their room without awaiting a response. Resident #303 indicated that they had been exposed on occasion when staff entered their room, that they were embarrassed and wished that the staff had waited to be invited into the room. Two PSW's interviewed confirmed their practice of entering the resident's room after a knock on the closed door and not waiting for an acknowledgement from the resident. [s. 3. (1) 1.]

WN #5: 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 did not 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.

The plan of care for resident #291 included a number of treatments.
A. In April 2013, a dressing was ordered to the resident's toe. The orders indicated that the dressing was to be changed every three days. The Treatment Administration Records (TAR) and wound assessment tools from October 2013, until January 2014, were reviewed. The dressing was not documented as being completed from October 16, 2013, until November 7, 2013, and from December 6, 2013, until December 18, 2013. Registered staff confirmed that the treatment was completed, however not recorded on the TAR.
B. A treatment cream was ordered to be applied to the resident's pelvic area three times a day beginning in October 2013. TAR's for November 2013, December 2013, and January 2014, did not include documentation that the treatment was administered by registered staff approximately twenty five percent of the time. Registered staff confirmed treatment was completed but not documented on the TAR's.
C. In November 2013, a second treatment cream was ordered to be applied three times a day due to the presence of a rash. A review of the TAR's for November 2013, December 2013, and January 2014, indicated that the treatment was not recorded as being applied by direct care staff approximately twenty percent of the time. Direct care staff confirmed that treatment was completed but not documented in the TAR's. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a registered dietitian who was a member of the staff of the home.

Resident #287 sustained a skin tear in December 2013, which was observed to be covered with a dressing on January 29, 2014. On January 29, 2014, it was confirmed by the RD, that she had not assessed the resident for the area of altered skin integrity, as there was no "diet requisition" submitted to communicate the need for the assessment. On a review of the clinical record no requisition was located for the area of altered skin integrity nor was there an assessment by the RD. [s. 50. (2) (b) (iii)]

2. The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff.

On December 4, 2013, registered staff noted an area of altered skin integrity on resident #317. The area was cleaned and a dressing was applied. The clinical record was reviewed from December 4, 2013, until January 30, 2014, and there was no reassessment of the area noted. Registered staff confirmed that there was no reassessment completed after the initial discovery of the area on December 4, 2013. [s. 50. (2) (b) (iv)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. This information was confirmed by the active Residents' Council Representative and in writing by the Administrator. [s. 85. (3)]

2. The licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. This information was confirmed by the active Residents' Council Representative and in writing by the Administrator. [s. 85. (4) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The resident who received any drug or combination of drugs, including psychotropic drugs, was not monitored nor had documentation completed for the response to and the effectiveness of the drugs.

Resident #287 was on a narcotic analgesic for ongoing reports of pain. The medication was adjusted by the physician on September 29, 2013, and again on November 28, 2013, in an effort to manage pain. The staff did not monitor and/or document the resident's response to this change in medication dosage. The DOC and registered staff interviewed identified that when there was a change in pain medication or a new analgesic ordered staff were to complete a Medication Effectiveness Review (MER) form for 12 days to monitor the effectiveness of the change. There was no evidence of a MER form completed for the 12 days after September 29, 2013, or November 28, 2013, located in the clinical record. [s. 134. (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee did not ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs and goods provided to the residents were communicated to the Residents' Council. This information was confirmed by the active Residents' Council Representative and in writing by the Administrator. [s. 228. 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

The homes "Immunization Protocols, CIC-02-14-1" indicated that "all residents shall be asked about the status of their tetanus and diphtheria boosters upon admission and, with informed consent, will be offered the vaccine if immunization status is unknown or more than 10 years since the last booster". Interview with the Administrator confirmed that tetanus and diphtheria was not being screened for nor offered to residents. [s. 229. (10) 3.]

Issued on this 4th day of February, 2014

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

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