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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 13, 2016	2015_384161_0025	035941-15	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED COUNTIES OF LEEDS AND GRENVILLE
746 County Road 42 P.O Box 100 ATHENS ON K0E 1B0

Long-Term Care Home/Foyer de soins de longue durée

MAPLE VIEW LODGE
746 COUNTY ROAD, 42 EAST P.O. BOX 100 ATHENS ON K0E 1B0

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

KATHLEEN SMID (161), ANANDRAJ NATARAJAN (573), WENDY BROWN (602)

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 4 - 8, 2016 and January 11, 12, 2016.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of Resident Council, President of Family Council, Housekeepers, Personal Support Workers (PSW), RAI Coordinator, Registered Practical Nurses (RPN), Registered Nurses (RN), Resident Services Supervisor, Director of Dietary/Housekeeping/Environmental Services Supervisor, Assistant Director of Care, Director of Care and the home's Administrator.

During the course of the inspection, the inspector(s) also conducted 1 Critical Incident Inspection and 2 Complaint inspections.

During the course of the inspection, the inspector(s) observed the delivery of Resident care and services, Resident rooms, Resident common areas, medication administration and a meal service. The inspector(s) reviewed Residents' health care records, salient home policies and procedures, staff work routines, Resident Council minutes and posted menus.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

1 WN(s)
0 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	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).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(a)(c), whereby the licensee failed to ensure that the written plan of care for each resident sets out the planned care for the resident and also provided clear direction to staff and others who provide direct care to the resident.

On January 07, 2016, Inspector reviewed Resident #041's written plan of care in effect on an identified date in January 2016. Under toileting, it directs staff to toilet the Resident before and after meals and also during bed time as per Resident's usual routine. Further the plan of care indicates that the Resident will attempt to go the toilet by self and therefore staff are to use pull ups for the Resident.

On January 08, 2016, Inspector spoke with PSW S#116, who stated that Resident #041 is incontinent for both bladder and bowel. The PSW S#116 indicated to the inspector that during her shift, the Resident is toileted in the morning and before or after every meal. Further the PSW S#116 indicated that the Resident wears a brief and is total dependent on staff for toileting.

Inspector spoke with PSW S#114, who indicated that Resident #041 is toileted in the morning, after breakfast, after lunch and dinner. Further the PSW S#114 indicated to the inspector that the Resident wears a medium brief, does not wear any pull ups and does not have the insight to toilet by self.

On January 08, 2016, during an interview RPN S#108 indicated to the Inspector that Resident #041 is incontinent for bladder and bowel. Further, RPN S#108 indicated that

currently the Resident is no longer using pull ups or attempt to toilet by self in the washroom. After reviewing the Resident's current written plan of care in place with the inspector, the RPN S#108 confirmed that the care plan is not updated and is not reflecting Resident #041's current toileting needs.

The written plan of care does not set out the planned care for the Resident #041's current toileting needs.

2. Throughout this inspection Inspector #573 observed Resident #032 sitting on a transfer sling while seated on an air cushion in a tilt wheelchair.

The progress notes on the health care record for Resident #032 was reviewed by the inspector and a progress note on an identified date in December 2015 indicates that the Resident had a blister on right buttock. There was no information regarding the cause of the blister.

Inspector spoke with PSW S#114 and PSW S#116 both indicated that the transfer sling is left under the Resident since it is very difficult for the staff to apply the sling for transfers due to Resident's physical limitation and behaviours. Both the PSW staff members agreed with the inspector that the transfer sling placed under the Resident in the wheelchair defeats the purpose of the wheel chair air cushion.

The inspector reviewed the plan of care, as identified by the home, and noted that Resident #032 was not care planned to sit on a transfer sling while in a wheelchair. Further the written plan of care in place had no information related to the use of a sling for the Resident while seated in a wheelchair due to any physical limitations or behaviours as mentioned by the nursing staff members.

3. On January 08, 2016 Inspector #573 observed Resident #030 to have a lap tray applied to the wheelchair while seated in the dining room during lunch meal service. PSW staff was feeding the Resident and the lap tray was observed to be removed at the end of meal service.

On January 11, 2016 inspector observed Resident #030 seated in the wheel chair with no lap tray and PSW S#114 feeding the Resident. Inspector spoke with the PSW S#114 regarding the use of Resident's lap tray who indicated that it is been more than a month that the use of wheel chair lap tray was discontinued.

On January 11, 2016 inspector spoke with PSW S#117 who indicated that Resident #030 to have wheel chair lap tray only during the meal time. Inspector reviewed the written plan of care in place for an identified date in January 2016 under Risk of falls it indicates that staff to use wheel chair seatbelt and lap tray when the Resident in the wheelchair.

On January 11, 2016, Inspector #573 interviewed RPN S#118 regarding the use of wheel chair lap tray. The RPN S#118 indicated that wheel chair lap tray is used only at the meal time to assist the Resident with the feeding. Inspector #573 reviewed Resident #030 written plan of care in the presence of RPN S#118 who confirmed that the care plan does not provide any clear direction to staff regarding the use of wheel chair lap tray for Resident #030 during meal time. The RPN S#118 further stated to the inspector that she will update the use of wheelchair lap tray for the Resident #030 in the written plan of care.

The written plan of care in place for Resident #030's does not provide clear direction to staff and others who provide direct care to the Resident regarding the use of wheel chair lap tray during meal times. [s. 6. (1)]

Issued on this 13th day of January, 2016

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

Original report signed by the inspector.