Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: November 3, 2022	
Inspection Number: 2022-1570-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: United Counties of Leeds and Grenville	
Long Term Care Home and City: Maple View Lodge, Athens	
Lead Inspector Darlene Murphy (103)	**Inspector Digital Signature** Darlene Murphy Digitally signed by Darlene Murphy Date: 2022.11.21 09:10:55 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 17-21, 24-25, 2022.

The following intake(s) were inspected:

- Intake: #00004538- [IL: IL-01990-OT]-written letter of complaint related to resident care and the operation of the long-term care home,
- Intake: #00005791- [CI: M554-000004-22]-resident fall that resulted in an injury,
- Intake: #00006981- [CI: M554-000002-22] and Intake: #00006872- [CI: M554-000005-22]-alleged incidents of staff to resident neglect and incompetent care.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Restraints/Personal Assistance Services Devices (PASD) Management

Infection Prevention and Control
Reporting and Complaints
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure the written policy to promote zero tolerance of abuse was complied with.

Rationale and Summary
An RPN emailed the Director of Care (DOC) to inform them of an alleged incident of resident neglect. The following day, a PSW informed the Resident Support Services Supervisor of the incident, and it was reported to the Director at that time.

A PSW emailed the DOC to inform them of an alleged incident of resident abuse. The DOC stated they received the email two days later and reported the incident to the Director at that time. The home's abuse policy was reviewed and indicated all employees are required to immediately report any suspected or known incident of resident abuse or neglect to the Administrator or designate in charge of the home. The DOC stated email would not be considered an acceptable method to ensure immediate reporting.

Failure to immediately report resident abuse or neglect puts residents at risk of additional harm.

Sources:
Critical incident reviews, interviews with the DOC and Support Services Supervisor, and review of the abuse policy. [103]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary:
A PSW left a resident unattended in their bathroom following an incident of bowel incontinence. The PSW advised the RPN and then returned to distributing snacks to other residents and subsequently left on break. The plan of care related to bowel continence for the resident indicated the resident required supervision and extensive assist of 1 staff member related to the resident having an unsteady gait.

Leaving the resident unattended during this incident, placed the resident at risk of harm from a fall.

Sources:
Support Services Supervisor, review of the resident health care record.
[103]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 174.1 (3)

The licensee has failed to ensure the policy directive for the use of glucagon was carried out.

Rationale and Summary:
In accordance with Minister's Directive, "Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia", effective April 15, 2020, the licensee was required to ensure that all direct care staff received training on the requirements of this Directive, the use of glucagon involving a resident was documented including the immediate actions taken to assess and maintain the resident's health and the reporting of the use to the resident's substitute decision maker. In addition, this directive required the licensee to ensure all uses of glucagon were reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

A resident received glucagon for the treatment of a blood sugar less than 4 mmol/liter. The resident health care record was reviewed and there was no documentation to reflect the reason the glucagon was administered, the actions taken to maintain the resident's health or the notification of the power of attorney (POA). The DOC stated they were unsure of the details regarding the administration of the glucagon to the resident and indicated a medication incident report was not completed. The Administrator stated medication incidents are reviewed as a part of the Professional Advisory Committee (PAC) quarterly and this is the process whereby the use of the glucagon would have been reviewed and analyzed and the corrective actions taken. Registered staff were interviewed and indicated they have never been provided training related to the use of glucagon.

Failure to comply with the Minister's Directives related to the use of glucagon could result in glucagon being improperly administered and lead to a negative outcome for the resident.

Sources:
Review of the resident health care record and interviews with the Administrator, the DOC and registered staff members.
[103]

WRITTEN NOTIFICATION: Licensee to Forward Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 22 (1)

The licensee has failed to ensure a written letter of complaint concerning the care of residents and the operation of the long-term care home was immediately forwarded to the Director.

Rationale and Summary:
A written complaint letter that included concerns related to resident care and the operations of the long-term care home was submitted to the Human Resources (HR) department. This written letter was subsequently shared with the Chief Administrative Officer. The complaint letter included allegations of improper cleaning of personal protective equipment, resident neglect, use of glucagon and unreported critical incidents. This written letter of complaint was not forwarded to the Director.

Failure to immediately forward written complaints regarding resident care and the operations of the home, puts residents at risk of harm.

Sources:
Written complaint letter, interview with HR.
[103]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1)

A person who had reasonable grounds to suspect resident neglect and incompetent care had occurred failed to immediately report the suspicion and information upon which it was based to the Director.

Rationale and Summary:
An RN reported to the DOC allegations of staff to resident incompetent care and neglect involving a PSW. The following day, anothe staff member submitted a written complaint to the DOC outlining allegations that five residents received incompetent care by the same PSW. The DOC stated the allegations were investigated but not reported to the Ministry of long-term care (MLTC) and was unsure of the reason the incidents were not reported.

Failing to immediately report all allegations of resident neglect and incompetent care to the Director, places residents at risk of harm.

Sources:
Letter of complaint, relevant email correspondence and interview with the DOC.
[103]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 101 (1) 3.

The licensee failed to ensure a response was sent to the complainant that outlined what the licensee had done to resolve the complaint.

Rationale and Summary:
A complaint letter was submitted to the HR department and subsequently to the licensee that outlined

concerns related to resident care and the operations of the long-term care home. The complaint letter was acknowledged as received, but a response that outlined the result of the home's investigation of the items brought forward was not provided to the complainant.

Sources:
Interview with complainant, email documentation provided by HR.
[103]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 101 (2)

The licensee failed to ensure a written complaint concerning the care of residents and the operation of the long-term care home was included in the home's documented record of complaints.

Rationale and Summary:
A written letter of complaint was received related to resident care and the operations of the long-term care home. HR stated the Acting Administrator was provided with the resident care details included in the complaint letter for actioning. The home's documented record of complaint was reviewed and did not include this written complaint. The documented record was noted to have no entries since January 2021.

Failing to track and analyze complaints, prevents opportunities to improve resident care.

Sources:
Review of the home's documented record of complaints, interview with HR.
[103]

WRITTEN NOTIFICATION: Reports Re: Critical Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (3) 4.

The licensee has failed to inform the Director within one business day of an incident whereby a resident was injured, sent to hospital and that resulted in a significant change in their condition.

Rational and Summary:
A resident sustained a fall, required transfer to hospital for further assessment and experienced a significant change in their condition. A critical incident was not submitted to the Director regarding this incident. The DOC indicated the previous DOC would have been responsible for submitting this incident and was unaware of the reason it was not submitted.

Failing to report critical incidents to the Director as legislated, places residents at risk of harm.

Sources:
Complaint letter, review of the resident health care record, interview with the DOC.
[103]