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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 2, 2013	2013_179103_0050	O-000871-13	Critical Incident System

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

DARLENE MURPHY (103)

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): October 1, 2013

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse (RPN), the Assistant Director of Care (ADOC), and the Director of Care (DOC).

During the course of the inspection, the inspector(s) made resident observations, reviewed the resident health care record, reviewed the home's investigation into the critical incident and reviewed the home's abuse policy.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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. The licensee has failed to comply with LTCHA, 2007, s. 24 (1) whereby staff that had reasonable grounds to suspect an incident of improper care of a resident had occurred failed to immediately report it to the Director.

On an identified date, S#101 assisted Resident #1 independently back to bed despite being aware the resident was a two person transfer. Following the transfer, the resident complained of pain. The pain was reported to the RPN on the unit, but S#101 did not disclose the details of the transfer. S#101 confided in S#102 that same day in regards to the one person transfer.

Over the next two days, Resident #1's pain worsened and S#101 and S#102 finally disclosed the details of the transfer to S#104. The information was then immediately reported to the ADOC.

In an interview with the ADOC, he indicated the Administrator, the police, the family and the MOHLTC were immediately notified and the investigation into the incident was initiated.

Both staff members were disciplined by the home as a result of the incident. [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 a person who has reasonable grounds to suspect improper care has occurred, immediately reports the suspicions to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 36 whereby a staff member did not use a safe transferring technique when assisting a resident.

In a written statement, S#101 advised on an identified date, he/she transferred Resident #1 to bed independently despite knowing the resident was a two person transfer. Resident #1's history was reviewed.

The current Physiotherapist assessment indicated Resident #1 required a two person transfer. Resident #1's plan of care indicated the same.

Following the one person transfer, Resident #1 immediately made verbal indications of pain. The staff member failed to ensure a safe transfer technique was utilized for this resident and the resident experienced pain as a result. [s. 36.]

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 Resident #1 is transferred using a safe technique and in accordance with the assessed plan of care, to be implemented voluntarily.

Issued on this 2nd day of October, 2013

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