Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 21, 24, ~~29, 30,~~ Jul 6, 2011	2011_071159_0010	Critical Incident

Licensee/Titulaire de permis

DALLOV HOLDINGS LIMITED
441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8

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

MAPLE VILLA LONG TERM CARE CENTRE
441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care, Administrator.

During the course of the inspection, the inspector(s) Interviewed Director of care, Administrator, reviewed resident's health record and home's policy and procedure for safe transferring and repositioning, falls preventions. Reviewed home's internal investigation related critical incident and the action plan.
Related to H-02600-10

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits sayants :

An Identified resident was not provided care set out in the plan of care.
Reviewed home's critical incident investigation noted that staff reported transferring the resident 2 person side by side and via sit to stand lift contrary to the plan of care which identified the need for maxi lift. [LTCHA,2007,c.8, s.6(7)]

Resident was not reassessed related to change in condition.
Progress notes identified that resident voiced complaint of pain and inability to move arm. There was no documentation to support that the resident was reassessed in relation to injuries and pain.
Resident's progress notes indicated that the Registered Practical Nurse (RPN) noted injuries and resident complaining of pain especially when touched during care. The Registered Practical Nurse had received verbal x ray report indicating a fracture. However, there was no record found that the resident was assessed after injury and significant change in condition. The plan of care was not revised to include interventions to address pain management in relation to injuries. Interview with the Director of Care confirmed that the resident was not reassessed and the plan of care not revised.
[Long Term Care Homes Act 2007, c. 8, 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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan of care,, to be implemented voluntarily.

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 sayants :

Staff did not use safe transferring devices and techniques when assisting resident.
An identified resident sustained injuries and fracture during a transfer or when being assisted. A review of Critical Incident report and interview with the Director of Care confirmed that the possible cause of resident's injuries would be " unsafe use of mechanical device, wrong size sling application and unsafe techniques." [O.Reg.79/10 s.36]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 19th day of August, 2011

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2011_071159_0010
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 21, 24, ~~29~~, 30, Jul 6, 2011
Licensee / Titulaire de permis :	DALLOV HOLDINGS LIMITED 441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8
LTC Home / Foyer de SLD :	MAPLE VILLA LONG TERM CARE CENTRE 441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BARBARA GOETZ

To DALLOV HOLDINGS LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that every resident is reassessed and the plan of care is revised at any time the resident's care needs change or care set out in the plan no longer necessary. The plan shall be submitted to Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and compliance Branch, Hamilton Service Area Office, 119 King Street west, 11th Floor, Hamilton, ON L8P 4Y7 by July 29, 2011

Grounds / Motifs :

1. The progress notes for an identified resident stated that resident voiced complaint of pain and inability to move arm. There was no documentation to support that resident was assessed in relation to injuries and pain and the plan of care reviewed and revised.

Resident's progress notes indicated that the Registered Practical Nurse (RPN) noted injuries and resident complaining of pain especially when touched during care. The RPN had received verbal X ray report indicating a fracture. Resident's attending physician was informed of the fracture. However, there no record found that the resident was assessed after injury and significant change in condition. The plan of care was not revised to include interventions to address pain management in relation to injuries.
Interview with the Director of Care confirmed that the resident was not reassessed and the plan of care not revised.

(159)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2011

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The plan shall be submitted to Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office, 119 King street West, 11th Floor, Hamilton, ON L8P 4Y7 by July 29, 2011.

Grounds / Motifs :

1. The staff did not use safe transferring devices and techniques when assisting resident.
An identified resident had sustained injuries and fracture, during a transfer or when being assisted. A review of critical incident report and interview with the Director of Care confirmed that the possible cause of resident's injuries would be "unsafe use of mechanical device, wrong size sling application and unsafe techniques". (159)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2011

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 19th day of August, 2011

Signature of Inspector / Signature de l'inspecteur : A. Sehgal

Name of Inspector / Nom de l'inspecteur : ASHA SEHGAL

Service Area Office / Bureau régional de services : Hamilton Service Area Office