Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_704682_0034	019752-19	Critical Incident System

Licensee/Titulaire de permis

Better Life LTC Inc.
147 Estate Garden Drive RICHMOND HILL ON L4E 3X8

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

AILEEN GRABA (682)

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): December 3, 4, 5, 6, 9, 10, 11, 12, 13, 2019.

This Critical Incident System inspection was done concurrently with Complaint inspection 2019_704682_0035:
020161-19 related to plan or care and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietician (RD), Registered nursing staff, Personal support workers and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, program evaluations, training records and policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

- **2 WN(s)**
- **2 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	Légende 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #001 set out clear direction to staff and others who provided direct care to the resident.

A Critical Incident (CI) was submitted to the Director. A clinical record review included a care plan which indicated that resident #001 was a risk for falls. The care plan also indicated that resident's #001 was to not have a particular fall intervention. Further review of the care plan indicated that resident #001 had various fall prevention strategies in place.

During an interview the Director of Care (DOC) confirmed that the written plan of care related to fall prevention did not set out clear direction to staff who provide care. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident (CI) was submitted to the Director. A clinical record review indicated that resident #001 was identified as a fall risk. A review of resident's care plan identified various fall prevention strategies.

During observations by Inspector #682, resident #001 did not have a fall intervention in place as indicated in their plan of care. During an interview, staff #100 confirmed that the fall intervention was not in place on an identified date. Staff #100 confirmed that the care set out in the plan of care related to resident #001 was not provided to the resident as specified in the plan.

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident (CI) was submitted to the Director. A clinical record review indicated that resident #001 was identified as a fall risk. A review of resident's care plan, identified various fall prevention strategies. Inspector #682 observations did not include a fall intervention identified in the plan of care on an identified date. During an interview staff #101 confirmed that they were providing care that shift for resident #001 and that they did not include the fall intervention to the resident on that shift. Staff #101 confirmed they failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment in the home in accordance with manufacturer's instructions.

A Critical Incident (CI) was submitted to the Director. A clinical record review indicated that resident #001 was identified as a high fall risk. A review of an assessment completed by staff #110 indicated resident #001 had sustained a fall. Staff #110 also identified an intervention to prevent re- occurrence. A progress note indicated staff #110 identified that resident's #001 intervention was not in place. A review of resident's #001 care plan, identified various fall prevention strategies.

Inspector #682 requested the manufacturer's instructions and was provided a document. During an interview, the DOC stated that they were aware and investigated the incident that involved resident #001 fall. The home did not ensure that staff use all equipment in accordance with manufacturer's instructions. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.