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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2021	2021_725522_0014	014374-21	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

The Maples Home for Seniors
94 William Street South P.O. Box 400 Tavistock ON N0B 2R0

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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 27, 28, November 1, 2, 8, 9, 10 and 15, 2021.

Complaint IL-93632-LO/ Log #014374-21 related to falls prevention, nutrition and hydration, personal support services and resident rights was inspected during this inspection.

Critical Incident System inspection #2021_725522_0013 was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Registered Nurses, a Registered Practical Nurse, Personal Support Workers (PSWs), a Restorative Care PSW, a Cook and a resident.

The inspector also observed staff to resident interactions, the provision of resident care and meal service; reviewed resident clinical records, the home's investigative notes, reporting and complaints logs, meeting minutes and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Head Injury Routine" policy was complied with.

O. Reg. 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Review of the home's "Fall Management Program – Post Fall Management" policy noted registered staff would initiate a Head Injury Routine with a witnessed fall with a head injury and with all unwitnessed falls.

Review of the home's "Head Injury Routine" policy noted a resident must be woken up to complete vital signs and the post head injury assessment if they were sleeping. A head injury routine (HIR) would be completed on all residents who received anti-coagulant medication i.e. Coumadin.

A) Resident #002 had an unwitnessed fall.

Review of resident #002's Post Head Injury Assessment Form noted on several occasions the assessment was not completed and the resident was noted as sleeping.

In an interview, Registered Practical Nurse (RPN) #108 reviewed resident #002's Post Head Injury Assessment Form and acknowledged the missing documentation. RPN #108 stated staff probably did not wake resident #002 because the resident was sleeping and the resident would be upset.

B) Resident #001 had a witnessed fall. Review of resident #001's Post Fall Investigation notes indicated resident #001 was on specific medication so a HIR was initiated.

Review of resident #001's Post Head Injury Assessment Form noted an assessment was not completed at a specific interval and resident #001 was noted as sleeping.

In an interview, Registered Practical Nurse (RPN) #108 reviewed resident #001's Post Head Injury Assessment Form and acknowledged the missing documentation. RPN #108 stated if a resident was sleeping they would try and rouse them but if the resident refused they would enter refused or sleeping.

RPN #108 stated resident #001 had most likely just gotten to bed at that time and because they used a specific device while sleeping staff would not have wanted to wake resident #001.

In an interview, the Director of Care (DOC) stated staff would usually wake residents to complete a HIR, but if the resident was not a good sleeper, they might not wake them up. The DOC stated resident #001 used a specific device while sleeping and usually refused it. The DOC stated if resident #001 was fine and their vitals were fine they would not expect staff to wake up resident #001 to complete the HIR as it was important for resident #001 to use their device while sleeping.

Post Head Injury Assessments were not completed as required for resident #001 and #002, this put the residents at actual risk as staff had the potential to miss post fall injuries.

Sources:
Review of resident #001 and #002's clinical records, the home's "Fall Management Program – Post Fall Management" policy #NP-S10-20.0 Revised/Reviewed March 2021, Review of the home's "Head Injury Routine" policy with a review date of September 2019, interviews with RPN #108 and the DOC. [s. 8. (1)]

Additional Required Actions:

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that care was provided to resident #001 as per their falls plan of care.

Review of resident #001's progress notes indicated that resident #001 had an unwitnessed fall.

Review of the Post Fall Investigation noted resident #001 was using their assistive device in an unsafe manner. Two Personal Support Workers (PSWs) had tried to intervene but resident #001 did not cooperate. The PSW then heard resident #001 fall and found the resident on the floor.

Review of resident #001's electronic clinical records in Point Click Care noted resident #001 was a high falls risk and their care plan stated that resident #001 would often use their assistive device in an unsafe manner and staff were to intervene and provide a specific option for the resident for safety. Resident #001's care plan also stated that due to resident #001's behaviours staff were to reapproach the resident when strategies did not work.

Resident #001's Quarterly Minimum Data Set (MDS) Assessment indicated resident #001 had poor decision-making skills at times which required staff to provide supervision to ensure appropriate decisions were made.

In an interview, Personal Support Worker (PSW) #105 stated prior to resident #001's fall, they found resident #001 using their assistive device in an unsafe manner. PSW #105 stated they tried to intervene but resident #001 refused to move. PSW #105 stated two other staff had tried to intervene as well but resident #001 refused to move. PSW #105 stated resident #001 was resistive and unsafe to transfer.

PSW #105 stated that they then went for their break and no one stayed with resident #001 as the resident was in the hallway just down from the nurses' station. PSW #105 stated they heard the code care when on they were on their break.

In an interview, the Director of Care (DOC) stated resident #001 had refused to move for two PSWs which the resident often did. The DOC stated there was not much staff could do if resident #001 was determined to use their assistive device inappropriately. The DOC stated staff would have been watching resident #001 as they were back and forth in the hallway.

Resident #001 was using their assistive device inappropriately, staff did not stay with resident #001 to reapproach the resident which put resident #001 at actual risk of injury when they had an unwitnessed fall.

Sources:
Review of resident #001's clinical records and interviews with PSW #105, PSW #106, RN #109 and the DOC.[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 resident #001 is provided care as per their falls plan of care, to be implemented voluntarily.

Issued on this 29th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2021_725522_0014
Log No. / No de registre :	014374-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 26, 2021
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	The Maples Home for Seniors 94 William Street South, P.O. Box 400, Tavistock, ON, N0B-2R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joan Hergott

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 8. (1)(b).

Specifically,
A) As per the home's policy, residents who are on a head injury routine (HIR) must be wakened to have HIR assessments completed.
B) The home will complete education with all registered staff members related to the home's head injury routine policy.
C) A record must be kept of the training, including the dates of the training and the staff members who completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's "Head Injury Routine" policy was complied with.

O. Reg. 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Review of the home's "Fall Management Program – Post Fall Management" policy noted registered staff would initiate a Head Injury Routine with a witnessed fall with a head injury and with all unwitnessed falls.

Review of the home's "Head Injury Routine" policy noted a resident must be woken up to complete vital signs and the post head injury assessment if they were sleeping. A head injury routine (HIR) would be completed on all residents who received anti-coagulant medication i.e. Coumadin.

A) Resident #002 had an unwitnessed fall.

Review of resident #002's Post Head Injury Assessment Form noted on several occasions the assessment was not completed and the resident was noted as sleeping.

In an interview, Registered Practical Nurse (RPN) #108 reviewed resident #002's Post Head Injury Assessment Form and acknowledged the missing documentation. RPN #108 stated staff probably did not wake resident #002 because the resident was sleeping and the resident would be upset.

B) Resident #001 had a witnessed fall. Review of resident #001's Post Fall Investigation notes indicated resident #001 was on specific medication so a HIR was initiated.

Review of resident #001's Post Head Injury Assessment Form noted an assessment was not completed at a specific interval and resident #001 was noted as sleeping.

In an interview, Registered Practical Nurse (RPN) #108 reviewed resident #001's Post Head Injury Assessment Form and acknowledged the missing documentation. RPN #108 stated if a resident was sleeping they would try and rouse them but if the resident refused they would enter refused or sleeping.

RPN #108 stated resident #001 had most likely just gotten to bed at that time and because they used a specific device while sleeping staff would not have wanted to wake resident #001.

In an interview, the Director of Care (DOC) stated staff would usually wake residents to complete a HIR, but if the resident was not a good sleeper, they might not wake them up. The DOC stated resident #001 used a specific device while sleeping and usually refused it. The DOC stated if resident #001 was fine

and their vitals were fine they would not expect staff to wake up resident #001 to complete the HIR as it was important for resident #001 to use their device while sleeping.

Post Head Injury Assessments were not completed as required for resident #001 and #002, this put the residents at actual risk as staff had the potential to miss post fall injuries.

Sources:
Review of resident #001 and #002's clinical records, the home's "Fall Management Program – Post Fall Management" policy #NP-S10-20.0 Revised/Reviewed March 2021, Review of the home's "Head Injury Routine" policy with a review date of September 2019, interviews with RPN #108 and the DOC.

Sources:
Review of resident #001 and #002's clinical records, the home's "Fall Management Program – Post Fall Management" policy #NP-S10-20.0 revised/reviewed March 2021, review of the home's "Head Injury Routine" policy with a review date of September 2019 and interviews with RPN #108 and the DOC.

An order was made by taking the following factors into account:

Severity: Head Injury Routine assessments were incomplete for residents #001 and #002 after they had a fall. This put the residents at actual risk as staff had the potential to miss post fall injuries.

Scope: The scope of this non-compliance was a pattern as the home's Head Injury Routine policy was not complied for two of three falls reviewed.

Compliance History: There was no previous noncompliance to this section of O. Reg. 79/10.
(522)

Ontario

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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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2022

REVIEW/APPEAL INFORMATION

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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