Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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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
May 1, 2019	2019_717531_0010	001859-18, 008042-18, 009661-18, 011179-18, 027135-18, 001479-19, 004084-19	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Maplewood
12 Maplewood Avenue Box 249 BRIGHTON ON K0K 1H0

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

SUSAN DONNAN (531), CATHI KERR (641)

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): April 16,17, 18, 23, 24, 25, 26, 29 and 30, 2019.

The following intakes were inspected:
Log #004084-19 Critical Incident #2171-000003-19 related to hospitalization and change in condition
Log #027135-18 Critical Incident #2717-000028-18 related to medication
Log #011179-18 Critical Incident #2717-000020-18 related to alleged resident to resident abuse
Log #009661-18 Critical Incident #2717-000018-18 related to alleged resident to resident abuse
Log #008042-18 Critical Incident #2717-000014-18 related to hospitalization change in condition
Log #001859-18 Critical Incident #2717-000004-18 related to alleged resident to resident abuse
Log #001479-19 follow up to CO #001 related to the falls prevention program

During the course of the inspection, the inspector(s) spoke with the Administrator (Admin), the Director of Care (DOC), the Clinical Care Coordinator (CCC), the RAI Coordinator (RC), the Program Registered Nurse (PRN), Registered Nurses (RN), Registered Practical Nurses (RPN), the Physiotherapy Assistant (PTA), the Physiotherapist, and residents.
During the course of the inspection, the inspectors conducted a walking tour of the home, observed resident care and services, reviewed residents' health care records, reviewed the medication management system, reviewed the fall prevention program, and reviewed the fall prevention policy and procedures and the Critical Incident reports and investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 48. (1)	CO #001	2018_749722_0003	531

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

An inspection was conducted with respect to Intake Log #008042-18, CIS #2717-000014-18 and Intake Log # 004084-19, CIS #2717-000003-19, related to residents #006 and #007 having sustained an injury resulting in a significant change in the resident's health condition for which the residents were taken to the hospital.

Documentation in critical incident (CIS) #2717-000003-19 indicated that on a specified date, resident #006 had sustained an injury. The injury had been treated and assessed by the doctor but did not improve. Resident #006's functional status declined and to prevent pressure on the injury, the resident's transfer status was changed to a full mechanical lift to avoid weight bearing. On a specified date , resident #006 was transferred to the hospital for further treatment. The critical incident was submitted to the Director on a specified date, eight business days after the documentation of the injury and change in functional status, and five business days after the resident was sent to the hospital for further treatment.

During an interview with Inspector #641 on April 23, 2019 at 1515 hours, the Director of Care (DOC) indicated that when resident #006 developed the injury, the resident was not allowed to weight bear to promote healing. The DOC advised that this deemed that the resident had a significant change of status. The DOC specified being aware that the critical incident had been submitted late, and not with in one business day.

During an interview with Inspector #641 on April 23, 2019 at 1130 hours, the Administrator (Admin) advised that after resident #006 had been sent to the hospital, the management team determined that the resident's injury would meet the parameters of a critical incident. The Admin specified that the licensee was aware that the critical incident had not been submitted in one business day as required by the Director.

Documentation in critical incident (CIS) #2717-000014-18 indicated that on a specified date, resident #007 sustained an injury from the night table when the resident was being assisted onto the commode. The resident began complaining of pain that was treated in the home with prn pain medication and had been referred to the doctor for assessment.

Resident #007 was sent to the hospital on a specified date for x-rays and it was reported on a specified date that the resident had sustained an injury. The critical incident was submitted to the Director on a specified date, eight business days after the incident and onset of pain, and three business days after the diagnosis of an injury.

During an interview with Inspector #641 on April 23, 2019 at 1130 hours, the Administrator (Admin) indicated that after resident #007 returned from the hospital on a specified date, when the injury had been diagnosed, the management team had reviewed the resident's health care record and determined that there had been a significant change in status due to the increase in the resident's pain. The Admin advised being aware that the critical incident had not been submitted within one business day as required.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the critical incidents that caused an injury to resident #006 and #007, that resulted in a significant change in the resident's health condition and for which the residents were taken to a hospital. [s. 107. (3) 4.]

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 the Director is informed of an incident no later than one business day after occurrence of an injury of which a person is taken to hospital, to be implemented voluntarily.

Issued on this 1st day of May, 2019

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

Original report signed by the inspector.