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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_542511_0013	017796-17	Follow up

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 6, 7 and 8, 2017.

Log # 017796-17 was completed during this inspection to follow-up on a Compliance Order for LTCHA 2007, S.O. 2007, Chapter 8, s.6(7) related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and identified residents.

During this inspection the Inspector toured the home and observed the provision of care, reviewed clinical records and applicable policy, procedures and related education documents.

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

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

1 WN(s)
0 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	Legendé 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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

On multiple identified dates in 2017, an observation of approximately 32 rooms was completed during the morning and afternoon shifts each day.

A. On a specified date in 2017, PSW #101 was observed leaving a resident room after providing assistance for an activity of daily living to resident #002. PSW #101 confirmed this task was completed independently. Interview with resident #002 confirmed they had received assistance from staff #101 independently.
Resident #002's most recent Minimum Data Set (MDS) assessment identified they were dependent and required two plus persons for physical assistance. A review of the resident's most recent resident assessment protocol (RAP), for the same period, identified the resident had a significant change in status when their condition had deteriorated and they required increased care.
The resident's plan of care for the same period identified the resident required two persons to provide extensive assistance for the activity of living identified above.

Interview with the DOC included a review of resident #002's plan of care. The DOC confirmed the plan of care was accurate, up to date and reflected the current needs of the resident. The DOC confirmed the plan of care had not been followed during the activity of living identified above.

B. On an identified date in 2017, PSW #100 was observed leaving resident #003 alone during an identified activity of daily living.
A review of the resident's clinical record described that the resident had a recent significant change indicating a deterioration in their health condition. According to this assessment, the resident required two plus persons for physical assistance and their Resident Assessment Protocol, for the same period, identified the resident's condition put them at risk for falls and they should not be left alone, unsupervised, during the identified activity of daily living.
A review of resident #003's most recent plan of care directed staff not to leave the resident unattended during the identified activity of daily living.

Interview with the DOC, on an identified date in 2017, included a review of resident #003's plan of care. The DOC confirmed the plan of care was accurate, up to date and reflected the current needs of the resident. The DOC confirmed the plan of care had not been followed when the resident was left unattended during the identified activity of daily living.

C. On and identified date in, 2017, resident #004 was observed to be alone during an

identified activity of daily living and had activated the call bell for assistance. Staff #102 had answered the call bell and provided assistance to resident #004 independently. A review of resident #004's most recent plan of care identified the resident required extensive assistance from two staff for this identified activity of daily living .

Interview with staff #102 stated that the resident had been left unsupervised when they responded to resident #004's call bell and that they provided assistance, independently, for the identified activity of daily living.

Interview with the DOC, on an identified date in 2017, included a review of resident #004's plan of care. The DOC confirmed the plan of care was accurate, up to date and reflected the current needs of the resident. The DOC confirmed the plan of care had not been followed, when the above identified staff had provided assistance independently for the identified activity of living. The DOC stated that, staff were to remain "close by" for supervision, which the DOC clarified as being in the resident's bedroom in order to provide resident safety.

2. A review of the Compliance Order #001, report 2017_574586_0016, dated August 1, 2017, ordered the Licensee to educate all PSW staff on the importance of following the plan of care related to the specified activity of living. This was to include a review of the circumstances of the incident as well as the order report with all staff and a discussion of the findings.

Interview with PSW #101 stated they had not received education as described in the Order and had received education when they had been hired on safe lift and transferring which included ensuring two staff were present for a mechanical lift transfer. The PSW stated they were not educated, as per the Order Compliance date of September 25, 2017, on the importance of following the plan of care for a specified activity of living, a review of the circumstances of the incident, provided in the grounds of Compliance Order #001 report 2017_574586_0016, nor a discussion of the findings.

Interview with the Administrator confirmed Order #001, as described in the Ministry of Health and Long Term Care Inspection report 2017_574586_0016, was not complied with as it related to education.

3. A review of the Compliance Order #001, report 2017_574586_0016, dated August 1, 2017, ordered the Licensee to conduct and document auditing activities, at regular intervals, during all shifts, to ensure the appropriate assistance and monitoring were

provided to the residents as specified in their plan of care for a specified activity of living. Specifically, ensuring no residents who required monitoring and assistance with the specified activity of daily living were left alone.

A request from the DOC for documents that included the auditing activities, as required by the Order described above, was not available.

Interview with the Administrator confirmed Order #001, as described in the Ministry of Health and Long Term Care Inspector report 2017_574586_0016, was not complied with as it related to auditing activities. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 8th day of December, 2017

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2017_542511_0013
Log No. / No de registre :	017796-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 17, 2017
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_574586_0016, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for resident #002, #003 and #004 is provided to the resident as specified in the plan, related to the assistance and monitoring for an identified activity of daily living as specified in the resident's plan of care.

The Licensee shall educate all PSW staff on the importance of following the plan of care related to the identified activity of daily living. This shall include a review of the circumstances of the incident provided in the grounds of Compliance Order #001, report 2017_574586_0016, with all staff and a discussion of the findings.

The Licensee shall also conduct and document auditing activities, at regular intervals, during all shifts, to ensure the appropriate assistance and monitoring are provided to the residents as specified in their plan of care related to the identified activity of daily living. Specifically, ensuring no residents who required monitoring and assistance for the identified activity of daily living are left alone.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This Order is based upon three factors where there has been a finding of noncompliance in keeping with section 299 (1) of Ontario Regulation 79/10, scope, severity and a history of noncompliance. The scope of noncompliance is a pattern (2), the severity of the non compliance is minimal harm or a potential

for actual harm (2) and the history of non-compliance under the LTCH, 2007, regulation 53 (4) is ongoing (4). The licensee was issued a Voluntary Plan of Correction (VPC) on July 27, 2015 and a Compliance Order (CO) on August 1, 2017.

On multiple identified dates in 2017, an observation of approximately 32 rooms was completed during the morning and afternoon shifts each day.

A. On a specified date in 2017, PSW #101 was observed leaving a resident room after providing assistance for an activity of daily living to resident #002. PSW #101 confirmed this task was completed independently. Interview with resident #002 confirmed they had received assistance from staff #101 independently.
Resident #002's most recent Minimum Data Set (MDS) assessment identified they were dependent and required two plus persons for physical assistance. A review of the resident's most recent resident assessment protocol (RAP), for the same period, identified the resident had a significant change in status when their condition had deteriorated and they required increased care.
The resident's plan of care for the same period identified the resident required two persons to provide extensive assistance for the activity of living identified above.

Interview with the DOC included a review of resident #002's plan of care. The DOC confirmed the plan of care was accurate, up to date and reflected the current needs of the resident. The DOC confirmed the plan of care had not been followed during the activity of living identified above.

B. On an identified date in 2017, PSW #100 was observed leaving resident #003 alone during an identified activity of daily living.
A review of the resident's clinical record described that the resident had a recent significant change indicating a deterioration in their health condition. According to this assessment, the resident required two plus persons for physical assistance and their Resident Assessment Protocol, for the same period, identified the resident's condition put them at risk for falls and they should not be left alone, unsupervised, during the identified activity of daily living.
A review of resident #003's most recent plan of care directed staff not to leave the resident unattended during the identified activity of daily living.

Interview with the DOC, on an identified date in 2017, included a review of

resident #003's plan of care. The DOC confirmed the plan of care was accurate, up to date and reflected the current needs of the resident. The DOC confirmed the plan of care had not been followed when the resident was left unattended during the identified activity of daily living.

C. On and identified date in, 2017, resident #004 was observed to be alone during an identified activity of daily living and had activated the call bell for assistance. Staff #102 had answered the call bell and provided assistance to resident #004 independently.
A review of resident #004's most recent plan of care identified the resident required extensive assistance from two staff for this identified activity of daily living .

Interview with staff #102 stated that the resident had been left unsupervised when they responded to resident #004's call bell and that they provided assistance, independently, for the identified activity of daily living.

Interview with the DOC, on an identified date in 2017, included a review of resident #004's plan of care. The DOC confirmed the plan of care was accurate, up to date and reflected the current needs of the resident. The DOC confirmed the plan of care had not been followed, when the above identified staff had provided assistance independently for the identified activity of living. The DOC stated that, staff were to remain "close by" for supervision, which the DOC clarified as being in the resident's bedroom in order to provide resident safety.

2. A review of the Compliance Order #001, report 2017_574586_0016, dated August 1, 2017, ordered the Licensee to educate all PSW staff on the importance of following the plan of care related to the specified activity of living. This was to include a review of the circumstances of the incident as well as the order report with all staff and a discussion of the findings.

Interview with PSW #101 stated they had not received education as described in the Order and had received education when they had been hired on safe lift and transferring which included ensuring two staff were present for a mechanical lift transfer. The PSW stated they were not educated, as per the Order Compliance date of September 25, 2017, on the importance of following the plan of care for a specified activity of living, a review of the circumstances of the incident, provided in the grounds of Compliance Order #001 report 2017_574586_0016, nor a discussion of the findings.

Interview with the Administrator confirmed Order #001, as described in the Ministry of Health and Long Term Care Inspection report 2017_574586_0016, was not complied with as it related to education.

3. A review of the Compliance Order #001, report 2017_574586_0016, dated August 1, 2017, ordered the Licensee to conduct and document auditing activities, at regular intervals, during all shifts, to ensure the appropriate assistance and monitoring were provided to the residents as specified in their plan of care for a specified activity of living. Specifically, ensuring no residents who required monitoring and assistance with the specified activity of daily living were left alone.

A request from the DOC for documents that included the auditing activities, as required by the Order described above, was not available.

Interview with the Administrator confirmed Order #001, as described in the Ministry of Health and Long Term Care Inspector report 2017_574586_0016, was not complied with as it related to auditing activities. [s. 6. (7)]
(511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2017

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 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 17th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Robin Mackie

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