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

Division des foyers de 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
Jul 22, 2019	2019_689586_0006	032924-18, 000964-19, 002462-19, 002464-19, 002465-19, 002466-19, 002469-19, 006047-19, 007801-19, 009484-19	Complaint

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

JESSICA PALADINO (586), CATHIE ROBITAILLE (536), KELLY HAYES (583)

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): April 23, 24, 25, 26, May 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, 30, 31, June 5, 6, 10 and 11, 2019.

The following Complaint Inspections were completed concurrently:
032924-18 - Personal Support Services, Continence Care & Bowel Management;
000964-19 - Medication Administration, Prevention of Abuse & Neglect;
006047-19 - Sufficient Staffing; Personal Support Services;
007801-19 - Dining & Snack Service; Residents Right; and,
009484-19 - Personal Support Services, Housekeeping.

The following Follow-Up Inspection were conducted concurrently:
002462-19 - Sufficient Staffing;
002464-19 - Medication Administration;
002465-19 - Personal Support Services;
002466-19 - Dining & Snack Service; and,
002469-19 - Sufficient Staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager (NM), Quality Improvement Coordinator (QIC), Resident Assessment Instrument (RAI) Coordinators, Attending Physician, Programs Manager, Behavioural Support Ontario (BSO), Administrative Assistant, Physiotherapist (PT), maintenance staff, restorative staff, dietary staff, ward clerks, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) toured the home, completed observations of the provision of care, medication administration, dining and snack services, resident programs and the homes environment. Inspector(s) reviewed resident clinical records including resident plans of care, policies and procedures, internal investigation notes, quality and improvement systems, staff training records and the staffing mix and payroll records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Snack Observation
Sufficient Staffing
Training and Orientation

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. 131. (2)	CO #013	2018_756583_0014	586
O.Reg 79/10 s. 31. (3)	CO #008	2018_756583_0014	586
O.Reg 79/10 s. 33. (1)	CO #007	2018_756583_0014	586
O.Reg 79/10 s. 73. (1)	CO #015	2018_756583_0014	586
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #010	2018_756583_0014	586

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

A) Resident #002 was admitted to an identified floor of the LTCH. Shortly after admission, the resident was moved to another floor. In interviews with registered staff #039 and #040, they confirmed that the resident's SDM was not notified of the move.

A progress note written by RAI Coordinator #005, documented a conversation with the resident's SDM indicating that the resident would need to be moved again for safety reasons, and would do so within the next day or two. Two days later, the SDM came into the home to discover that the resident had been moved back to the other floor. In an interview with the RAI Coordinator, they confirmed that they did not contact the SDM prior to the move (586).

B) Resident #003 received testing which lead to a diagnosis shortly after admission. On an identified date in 2019, the SDM for resident #003 was to meet with the specialist to discuss the results the testing. During interview, resident #003's physician confirmed that prior to the meeting with the specialist, they had spoken with the SDM and advised them

to meet with the specialist and then set up a meeting through the home to discuss the future plan of care.

During interview, the SDM advised the LTCH Inspector that they had called and left messages multiple dates for registered staff #013 and did not receive return calls. Seven days later, the SDM finally reached registered staff #013 who advised the SDM that they had not received any of their previous messages. During interview with registered staff #013, they advised the LTCH Inspector that they did not have an individualized voicemail box, and that any messages went to a general mailbox. During interview with the DOC, they stated that the home's protocol was that the general voicemail box was to be checked once per day by the nursing staff, if staff see the message light illuminated.

The following day, a meeting was booked for the SDM to meet with the resident's physician on a later date that month, to discuss the plan of care; however, resident #003 no longer resided in the home prior to the meeting with the residents physician.

During interview, the DOC and resident #003's physician confirmed that the SDM was not given an opportunity to participate fully in the development and implementation of resident #003's plan of care.

C) A progress note in resident #002's chart, written by registered staff #013 at the time of admission, identified that resident #002 had a condition which required medical intervention.

Five days later, registered staff #021 documented that the SDM had agreed to starting a the intervention, and that they hoped it would be in place within two days. During interview registered staff # 021, they confirmed that the request for the order for the intervention would have been put into the physician's file to be ordered on their next visit, which was scheduled for three days from then, rather than two, but this was not shared with the SDM. The intervention was ordered and started the day following the physician's visit.

During interview with the DOC, a review was completed of the progress notes identifying the SDM's expectation that the intervention would be started on an identified date; two days prior to when it was actually implemented. The LTCH Inspector asked the DOC if someone should have advised the SDM that the intervention would not be ordered until the physician's visit, which would delay the start date. The DOC confirmed that the SDM should have been given the opportunity to participate in the plan of care for resident

#002. [s. 6. (5)]

2. The licensee has failed to ensure that resident #004 received the care set out in their plan of care.

Afternoon nourishment pass was observed on an identified date during the inspection, completed by PSW #010. From 1430 to 1600 hours, resident #004 was observed sleeping in bed with a glass of fluid and a snack on their bedside table. According to the resident's documented plan of care, staff were to provide a specific amount of fluid at meals and snacks. The resident only received one glass of fluid. Resident #004 did not receive the care set out in their plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that every resident's plan of care was reviewed and revised when the resident's care needs changed.

During the inspection, it was brought to the LTCH Inspector's attention that resident #017 required a specific grooming task on a daily basis. The LTCH Inspector, along with the Quality Improvement Coordinator, PSW's #017, #019 and #020, and the resident's SDM, had a discussion at the nurse's station about the resident's need for the daily grooming, using a specific tool that was labelled in their bathroom with their name and a note saying to use daily. The SDM was in agreement with this and staff said they would implement this moving forward. Two days later, the resident's documented plan of care, which front line staff use to direct care, had not been updated to reflect this grooming need for the resident. This was confirmed by the QIC. [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 to ensure that every resident, or the resident's substitute-decision maker, if any, are given the opportunity to participate fully in the development and implementation of the residents' plan of care, to be implemented voluntarily.

Issued on this 30th day of July, 2019

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

Original report signed by the inspector.