Ontario

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2019	2019_546750_0017	016156-19, 016732-19, 022027-19	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

STACEY GUTHRIE (750), JESSICA PALADINO (586)

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): November 19, 20, 21, 22, 25, 25, and 27, 2019.

The following intakes were completed during this complaint inspection:
log #022027-19 related to continence care and bowel management
log #016732-19 related to continence care and bowel management, and
log # 016156-19 related to staffing and medication.

This inspection was completed concurrently with critical incident system inspection # 2019_546750_0018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, Resident Assessment Instrument (RAI) coordinator, physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN) personal support workers (PSW), family members and residents.

During the course of this inspection, the inspector (s) observed the provisions of resident care, reviewed clinical health records, assessments, investigation notes, staffing schedules, meeting minutes, policies and procedures and the home's complaint log.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the continence care and bowel management program must, at a minimum, provide for strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aides.

A. The Director received a complaint, outlining care concerns regarding resident #001.

In an interview with the resident's substitute-decision maker (SDM), they indicated that the resident had a sudden change in their toileting plan.

In an interview with Personal Support Workers (PSW) #102 and #107 and Registered Nurse (RN) #105, it was shared that the licensee rolled out a new policy indicating that residents requiring the use of a Hoyer lift, would no longer be toileted using the toilet and would use an specified personal care item or incontinence product only. It was identified that this was implemented on November 15, 2019

A memo was provided to Inspector #586, it was reported that it was sent out to staff on a specified date, stating the following, 'Residents who require a Hoyer lift for transfer will NOT be toileted on a toilet". The licensee's policy, "Mechanical Lift and Transferring Devices", dated at an earlier identified date, indicated, "Residents who require a hoyer lift will not be toileted on the toilet".

The plan of care indicated that on an identified date, the resident's toileting plan was changed from being transferred to the toilet using the hoyer lift and toileting sling to not being placed on toilet and having to use their incontinence product.

In an interview with the Physiotherapist (PT) #108 , they confirmed that the change was made without any reassessment of the resident and there was no evidence that the change was clinically indicated.
(586)

B. A review of a complaint, identified concerns regarding resident #002's toileting routine being changed from using the toilet to using a bedpan.

A review of resident #002's written plan of care identified that prior to the implementation of this new policy, resident #002 was assessed to be toileted using a hoyer lift and toileting sling.

On an identified date during the inspection, two personal support workers (PSW) were observed entering resident #002's room with a bed pan and a hoyer lift. PSW #106 confirmed afterwards that resident #002 used bedpan as per the home's new policy, which included any resident who requires a hoyer lift cannot be toileted on the toilet.

A review of the written plan of care showed that resident #002 was changed from being placed onto the toilet using a hoyer lift and toileting sling to using a bedpan or their incontinence product. No documentation was found regarding a reassessment to the resident's toileting plan and no evidence that the resident and or the resident's substitute decision maker were given an opportunity to particular in any decision related to resident #002's toileting plan.

A discussion with resident #002's family, confirmed that they were not involved in the change and they expressed that it was not the resident or the SDM's preference.

C. On an identified date during the inspection, Resident #003 approached Inspector #750 related to concerns regarding the change to their toileting plan. The resident shared that their toileting plan was changed without their input and not as per their preference. The resident shared that it was their preference to be toileted on the toilet and they were now being told to use a bedpan and they indicated that the bedpan provided was too small for their use.

A review of the written plan of care, identified that the resident had brought forward their concerns regarding the change to their toileting plan.

In an interview with PT #108, it was confirmed that the resident's toileting plan prior to the implementation of the new policy was to use a hoyer lift with a toileting sling on the toilet and was changed to using a bedpan. The PT#108 confirmed that there was no clinical indication that the resident required the change to their toileting plan.

In an interview with clinical coordinator #104, they confirmed that the home only had a supply of slipper bedpans, which were small and not ideal for regular use, at the time of the inspection.

D. On an identified date during the inspection, resident #004 was overheard by Inspector #750, asking staff to use the toilet. Staff informed resident #004, they were not allowed to toilet them anymore and provided resident #004 with two options, to either use a

bedpan or their incontinence product.

A review of resident's plan of care, it was identified that the resident was assessed to use a hoyer lift and toileting sling as per their toileting plan and the resident's toileting plan was changed to use a bed pan or their incontinence product. There was no evidence of clinical indication for the change found in the review.

In an interview with resident #004, they said that the home wanted them to use a bed pan but it wasn't their preference. Resident #004 shared that they felt their independence was being taken away not being able to use the toilet. They also acknowledged that it wasn't very dignifying to not be able to use the washroom.

In an interview with PT #108, they advised that they were not involved in the development of the policies associated with the home's new Safe Lift Ambulation and Transfers for Everyone (SLATE) program. They did indicate that they were consulted regarding the program and they advised the need for exceptions to the policy to meet resident's individual needs.

In an interview with Director of Care (DOC) #101, they acknowledged that a new program, SLATE was initiated in the home as of November 15, 2019. The DOC could not provide evidence that the program addressed individual resident needs at the time of the interview.

The Administrator agreed that the newly implemented toileting policy was universal and did not maximize the resident's independence, comfort and dignity.

The home failed to ensure that the home's toileting plans at a minimum, provide strategies to maximize resident's independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

As per s.86(2)(b) of the Long Term Care Homes Act, the infection prevention and control (IPAC) program must include measures to prevent the transmission of infections, which includes but is not limited to how personal items are assigned, labelled and stored.

A review of complaint log #022027-19 identified concerns regarding resident #002's toileting routine changing from the resident being assisted to the toilet to being assisted to a bedpan or using their incontinence product. The complainant identified concerns regarding IPAC measures with regards to the bedpans being used in the home.

On an identified date, two personal support workers (PSWs) were observed walking from the dirty utility room to resident #002's room carrying a bedpan. PSW #106 confirmed that the resident used the bedpan.

In an interview, Personal Support Worker (PSW) #107 confirmed that the home was using a centralized stock of bedpans for any resident who was identified to have to use the bedpan and that the bedpans were not labelled or assigned to a specific resident. Following the discussion, Inspector #750 observed the dirty utility room and found seven (7) unlabeled slipper bedpans stored in a cupboard above the sink.

Review of policy IPAC-IV-35, titled "Resident Personal Care Supplies", with a specified date, states, "the Resident's personal care supplies will be appropriately used, labelled, cleaned and disinfected to prevent transmission of micro-organisms". A control measure identified in the procedure, notes "all resident care supplies must be individually labeled" and under storage and handling of personal care supplies, it notes to never store clean supplies in dirty area such as the dirty utility room.

In an interview with Director of Care (DOC) #101, they acknowledged that the bedpans should be assigned to each resident and labeled accordingly. DOC #101, confirmed that the bedpans were not labelled and should have been.

In an interview with the Clinical Manager #104, they confirmed that the home was ordering storage bags for clean bedpans to be properly stored following disinfection and did not have them in place at the time of the inspection.

The home failed to ensure that staff participated in the implementation of the infection control program to ensure that residents' personal care supplies were labeled and stored effectively to reduce exposure and transmission of micro organisms.

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 the licensee shall ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 16th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère 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) :	STACEY GUTHRIE (750), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2019_546750_0017
Log No. / No de registre :	016156-19, 016732-19, 022027-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 13, 2019
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Cedarwood Village 500 Queensway West, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marci Hutchinson

To Maplewood Nursing Home Limited, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:

1. Treatments and interventions to promote continence.
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.
3. Toileting programs, including protocols for bowel management.
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, 51(1)(4), the continence care and bowel management program must, at a minimum, provide strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

Specifically, the licensee must :

A. Ensure resident #001, #002, #003, #004 and all other residents who require a hoyer lift are assessed by a member of a registered staff (i.e. registered nurse, physiotherapist, etc.) to determine their capability to be toileted on the toilet. Maintain documentation of all residents who have been assessed and any reassessments moving forward.
B. Ensure that all residents and/or resident's substitute decision makers are given an opportunity to participate fully in the development and implementation of the residents' toileting plan. Maintain associated documentation.
C. Ensure that the home has adequate supplies, equipment, devices and assistive aids to support continence care and bowel management.
D. Ensure that the policy is updated to reflect any changes to the toileting program in the home and that the policy provides clear direction for staff. Ensure that copies of previous policies are kept in the home to reflect changes made.

Grounds / Motifs :

1. The licensee has failed to ensure that the continence care and bowel management program must, at a minimum, provide for strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aides.

A. The Director received a complaint, outlining care concerns regarding resident #001.

In an interview with the resident's substitute-decision maker (SDM), they indicated that the resident had a sudden change in their toileting plan.

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A discussion with resident #002's family, confirmed that they were not involved in the change and they expressed that it was not the resident or the SDM's preference.

C. On an identified date during the inspection, Resident #003 approached Inspector #750 related to concerns regarding the change to their toileting plan. The resident shared that their toileting plan was changed without their input and not as per their preference. The resident shared that it was their preference to be toileted on the toilet and they were now being told to use a bedpan and they indicated that the bedpan provided was too small for their use.

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In an interview with clinical coordinator #104, they confirmed that the home only had a supply of slipper bedpans, which were small and not ideal for regular use, at the time of the inspection.

D. On an identified date during the inspection, resident #004 was overheard by Inspector #750, asking staff to use the toilet. Staff informed resident #004, they were not allowed to toilet them anymore and provided resident #004 with two options, to either use a bedpan or their incontinence product.

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The Administrator agreed that the newly implemented toileting policy was universal and did not maximize the resident's independence, comfort and dignity.

The home failed to ensure that the home's toileting plans at a minimum, provide strategies to maximize resident's independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2020

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
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 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)
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 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 13th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stacey Guthrie

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