Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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 2, 2019	2019_727695_0009	006563-18, 007569-18, 009555-18, 020630-18, 024768-18, 028579-18, 028643-18, 000082-19	Critical Incident System

Licensee/Titulaire de permis

2063415 Ontario Limited as General Partner of 2063415 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Boulevard BRAMPTON ON L6R 3B5

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

FARAH_ KHAN (695), AMANDA OWEN (738), HEATHER PRESTON (640)

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): March 29, April 2, 3, 4, 5, 8, 12, 15, 16, and 17, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
Log #006563-18, related to a fall with injury
Log #007569-18, related to a fall with injury
Log #009555-18, related to a fall with injury
Log #020630-18, related to alleged staff to resident abuse
Log #024768-18, related to a fall with injury
Log #028579-18, related to alleged staff to resident abuse
Log #028643-18, related to a complaint submitted to the home
Log #000082-19, related to a fall with injury

During the course of the inspection the inspectors observed the provision of care and services, reviewed relevant documents including: clinical records, policies and procedures, and training records.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), registered practical nurses (RPN), student RPN, Registered Nurses (RN), Physiotherapist (PT), Occupational therapist (OT), Registered Dietician (RD), Behavioural Support Manager, Resident Program Team Member, Resident Relations Coordinator/Interim Program Manager, The Assistant Director of Care (ADOC), the Director of Care (DOC),and the Executive Director.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

2 WN(s)
1 VPC(s)
0 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 failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including falls prevention and management, required under section 48 of this Regulation that included relevant policies and provided for methods to reduce risk and monitor outcomes. Specifically, staff did not comply with the home's "Falls Prevention" policy, which was part of their falls prevention and management program.

The home's policy, "Falls Prevention" directed staff to not move a resident after a fall occurs until a preliminary assessment is completed. In addition, it stated that visitors are to be removed from the immediate area.

On a specific date at a specific time, the LTCH inspector informed PSW #112 that a resident was on the floor. The PSW and a visitor were observed lifting the resident from the floor without assessing the resident or asking other staff for assistance.

The LTCH inspector then observed RN #124 inform PSW #112 that when a resident has fallen, they must be assessed by an RPN prior to being moved.

The DOC acknowledged that resident #012 should not have been moved until they were assessed by a registered staff and the resident should not have been moved with assistance from a visitor.

The licensee failed to ensure that the home's "Falls Prevention" policy was complied with. [s. 8. (1) (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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with. Specifically to follow their "Falls Prevention" Policy, to be implemented voluntarily.

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 provision of care set out in the plan of care was documented for resident #015.

A Critical Incident System (CIS) report was reviewed by the LTCH inspector related to an incident where resident #015 wanted to attend a specific activity of interest on a specific date, but was put to bed at that time instead.

Resident #015 told the LTCH inspector that PSW #128 did not take them to their specific activity of interest as requested on on that specific date, and instead put them to bed.

The resident also said that this had continued to occur for a long period of time. The resident said they loved the specific activity and wanted to go unless they were sick.

A review of resident #015's plan of care in place at the time, identified suitable activities for the resident which included the specified activity.

Resident Program Team member #129, told the LTCH inspector that resident #015 liked to participate in the specific activity and that staff were expected to document the resident's response to being asked to participate in the specific activity in the home's electronic activity documentation system.

A review of seven months of the Multi-Day Participation Reports completed for resident #015, did not identify any documentation regarding the resident's attendance at the specific activity a total of 29 out of 108 potential times.

Resident Program Team member #129 reviewed the Multi-Day Participation Reports for resident #015, on the dates where there was no documentation, and told the LTCH Inspector that the documentation was not completed as required, related to the specified activity.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for resident #015. [s. 6. (9) 1.]

2. The licensee has failed to ensure that resident #008's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a CIS Report to the MOHLTC, related to an incident that caused injury to resident #008 for which the resident was taken to the hospital.

Record reviews and interviews with RPN #113 and PSW #114 showed that on a specific date, resident #008 required an intervention to be in place for falls prevention.

Observations by the LTCH inspector, RPN #113 and PSW #114 on that specific date showed that resident #008 did not have the intervention in place as per the resident's plan of care.

The ADOC was interviewed the same date and acknowledged that resident #008 did not

have the intervention in place as outlined in their plan of care and they stated they would follow up on this issue.

The following date, the ADOC stated that resident #008 no longer required the intervention and it had been removed from the resident's plan of care.

The licensee has failed to ensure that resident #008's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary [s. 6. (10) (b)]

Issued on this 6th day of May, 2019

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

Original report signed by the inspector.