Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: October 15, 2024
Inspection Number: 2024-1028-0004
Inspection Type: Critical Incident
Licensee: Maplewood Nursing Home Limited
Long Term Care Home and City: Maple Manor Nursing Home, Tillsonburg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2, 3, 4, 7, 8, 9, 2024

The following intake(s) were inspected:
· Intake: #00116359 - CIS: 1049-000012-24 - Related to prevention of abuse and neglect.
· Intake: #00122824 - CIS: 1049-000021-24 - Related to prevention of abuse and neglect.
· Intake: #00124401 - CIS: 1049-000023-24 - Related to medical event management.
· Intake: #00124637 - CIS: 1049-000025-24 - Related to improper/Incompetent care.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

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

Rationale and Summary
A policy in the home provided specific guidelines for residents who suffered from a specific medical event.

A resident had a specific order to be followed if they experienced a specific medical event.

The resident experienced a medical event in August 2024. The registered nurse (RN) did not follow the resident's specific order or the home's policy as required. The Critical Incident (CI) report stated that the resident started to decline, and another intervention was administered. The resident required further medical assessment.

Assistant Director of Care (ADOC) acknowledged that the correct intervention was

not followed for the resident.

There was risk to the resident when the medical monitoring was not completed as per their plan of care, and the resident required additional medical services.

Sources: resident's clinical records; home's Policy and interviews with ADOC and other staff.

[705241]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure a resident was not neglected by the home's staff.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
The home submitted a critical incident system report (CIS) that stated Personal Support Worker (PSW) reported to a Registered Practical Nurse (RPN) that a resident had been toileted only once between the hours of 1300-0300 hours on the shift.

During a telephone interview, the RPN stated the resident was assessed, and they were noted to have a strong smell of urine.

The Director of Care (DOC) said that the home's security footage was reviewed, and staff were interviewed, and it was determined that the resident had not received care for approximately eight hours.

Failure to provide the resident with the necessary care by staff risked the health and well-being of the resident.

Sources: CIS report; the home's investigative notes; the resident's clinical records including assessments, Point of Care (POC) documentation, progress notes, and interviews with staff and DOC.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of alleged abuse to a resident was

immediately reported to the Director.

Rationale and Summary
A resident alleged that they were abused by staff during care. A critical incident system (CIS) report was submitted a day after the allegation.

A Registered nurse (RN) acknowledged that they did not immediately report an allegation of abuse to the director.

The Director of Care (DOC) said that it would be the expectation that all allegations of abuse would be reported immediately to Ministry of Long-term Care and staff should submit even when it is after hours.

Failure to immediately report an allegation of abuse to the Director, placed the resident at risk for further harm or abuse.

Sources: Review of CIS report, interview with an RN and the DOC and resident's progress notes.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
Review of a Critical Incident System (CIS) report documented a resident was transferred by two Personal Support Workers(PSWs) with a mechanical lift, which caused injury to the resident.

Review of Lifting and Transferring a Resident Policy III Nursing General, last reviewed April 19, 2017 stated that "When using a mechanical lift there should always be two staff members. One staff member to control the mechanical lift and one to guide the Resident in the sling."

In an interview, Director of Care (DOC) acknowledged that it had been determined during the home's investigation that PSWs did not complete the transfer properly which caused the resident to sustain an injury. The DOC stated that the resident sustained an injury but recovered well after the incident.

There was an increased risk for injury to the resident when safe transferring techniques were not followed.

Sources: Review of CIS report, review of Lifting and Transferring a Resident Policy III Nursing General, last reviewed April 19, 2017, review of resident clinical records, review of home's investigation notes, and interview with DOC.

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WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for a resident.

Rationale and Summary
In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the Head Injury Policy Section: III Nursing General was complied with as a part of the Falls Prevention and Management Program. Specifically, staff did not comply with the licensee's Head Injury Policy Section: III Nursing General which was part of the licensee's Falls Prevention and Management Program.

Review of Head Injury Routine (HIR) initiated for a resident noted that the HIR was not completed at two specific times:
-At one specific date and time It had been recorded: "unable to do due to time constraints."
-At another specific time and date, all monitoring was completed except hand grip and pupils and it was recorded: "sleeping"

In an interview, Assistant Director of Care (ADOC) acknowledged that the HIR for the resident was not completed in full as per policy. ADOC stated the HIR should be completed in full and if the resident was sleeping, they were to be wakened and the

neurological assessment completed.

There was risk to the resident when they were not neurologically assessed for changes in their level of consciousness or responsiveness for time periods lasting as long as 24 hours.

Sources: The Head Injury Routine Policy III Nursing General, last reviewed April 19, 2017, resident's clinical records, interviews with staff and the DOC.

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