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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: December 2, 2024

Inspection Number: 2024-1028-0005

Inspection Type:
Critical Incident
Follow up

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): November 12, 13, 14, 18, 19, 2024

The following intake(s) were inspected:

- Intake: #00124526 - Follow-up #: 1 - CO #001/2024_1028_0004- O. Reg. 246/22 - s. 102 (9) (a)
- Intake: #00128212 -1049-000031-24 related to a fall.
- Intake: #00128953 -1049-000032-24 related to an allegation of staff to resident abuse.
- Intake: #00129031 -1049-000033-24 related to improper care of a resident.
- Intake: #00129793 -1049-000035-24 related to an allegation of resident to resident abuse.
- Intake: #00130135 -1049-000036-24 related to an allegation of resident to resident abuse.
- Intake: #00130339 -1049-000037-24 related to an allegation of visitor to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1028-0003 related to O. Reg. 246/22, s. 102 (9) (a)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
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,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

Summary and Rationale
A review of the progress notes in Point Click Care for a resident indicated that the home had implemented an intervention for the resident related to safety. The resident's plan of care did not include the intervention. An inspector observed the intervention to be in place.

During separate interviews with two staff members, both staff stated that the intervention was in place and that they expected that it would be included in the resident's plan of care, but it was not. After an interview with a staff member, the resident's plan of care plan was updated to include the intervention.

There was no impact noted as the intervention was in place during observations.

Sources: Clinical records for a resident, observations of a resident, and interviews with staff members.

Date Remedy Implemented: November 18, 2024

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care

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.

The licensee has failed to ensure that a care task for two residents was documented.

Summary and Rationale
A task was implemented for two residents. A review of the clinical records for each resident did not include documentation of the task. An order had been entered for one resident to implement the task, however, the order entered did not require documentation.

A Registered Nurse (RN) said that it was expected that the tasks were documented as a task on Point Click Care by Personal Support Workers and that registered nursing staff were to sign off to confirm that the tasks were completed. They said that the task should have been added to the task list for the two residents, but was not. The RN also said that the order for one resident had been added in error and that the staff member should not have selected "no documentation required." There was a risk that the task was not completed the two residents when it was not documented.

Sources: Clinical records for two residents, and interviews with an RN and other staff.

WRITTEN NOTIFICATION: Skin and Wound Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident, who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Rationale and Summary:
A Critical Incident System report (CIS) was received by the Director, concerning allegations of improper or incompetent treatment or care of a resident.

During a record review it was noted that when allegations of staff to resident abuse were received, a head to toe assessment was completed on the resident, with areas of altered skin integrity identified. An inspector was unable to find documentation of reassessments of the identified areas on several dates.

During an interview, the Director of Care (DOC) confirmed that weekly skin assessments were not completed on several dates, but should have been.

By not ensuring that weekly assessments were completed using a clinically appropriate assessment instrument, the resident was at risk for delayed wound care and could impact the resident's quality of life.

Sources: record review of clinical records and interview with DOC

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a behavioural assessment tool, which was initiated for a resident, was completed as per the expectations of the home.

Rationale and Summary
A behavioural assessment tool was initiated for a resident. The tool was not fully completed as per the expectations of the home.

A staff member said that the assessment tool was to be completed by Personal Support Worker (PSW) staff. They said that the tool was not completed as per the expectations of the home.
There was low risk to the resident as a result of staff not completing the assessment tool for resident as per the expectations of the home.

Sources: Clinical records for a resident and staff interviews.

WRITTEN NOTIFICATION: Notification of resident's substitute decision-maker

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that the substitute decision-maker (SDM) for a

resident was notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary:
A Critical Incident System report (CIS) was received by the Director, regarding allegations of improper treatment or improper care of a resident.

During an inspection, the clinical record for the resident did not identify documentation indicating their SDM had been notified of the results of the investigation immediately upon the completion of the investigation. Additionally, the long-term care home's investigation file of the allegations did not reflect that notification of the SDM had been completed.

In an interview with the Director of Care (DOC), they confirmed the home did not follow-up with the resident's SDM about the outcome of the investigation.

When the home did not notify the SDM of the results to the required investigation immediately upon completion of the investigation, the resident was not placed at risk or impacted by the home's omission.

Sources: interview with DOC; and record review of CIS investigation file, resident clinical records.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint made to a staff member concerning the care of a resident was immediately investigated and that a response was provided within 10 business days of the receipt of the complaint.

Rationale and Summary:

A Critical Incident System report (CIS) was received by the Director regarding allegations of resident abuse and neglect. During an inspection, no documentation was found in the clinical record for a resident or in the CIS report file indicating that a verbal complaint made to staff member concerning the care of a resident was immediately investigated and that a response was provided within 10 business days of the receipt of the complaint.

In an interview with a staff member, they recounted that, when they became aware of an allegation of abuse, they did not report, investigate, or document the allegations of resident abuse.
Interviews with the Director of Care and with the Administrator confirmed that the complaints process was not followed.

When a staff member did not immediately assess, investigate or report the allegations of abuse, a resident did not immediately receive the treatment, care, services, or assistance required for their health, safety, or well-being.

Sources: interview with a staff member, DOC and Administrator; and record review of CIS investigation file, and resident clinical records.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:

1. Protect two residents from abuse by another resident. Ensure the home continues to implement a specified intervention for the resident who was the aggressor.

Grounds

The licensee has failed to protect two residents from abuse by another resident.

Summary and Rationale

Two Critical Incident System (CIS) reports reported separate allegations of abuse of two residents by another resident. A third incident was also reviewed, which was not investigated or reported to the Director or the home's management team.

Both residents, who were victims, exhibited distress at the time of the incidents.

There was a moderate risk to two residents when the licensee failed to protect them from abuse by a resident.

Sources: CIS reports, clinical records for residents, and interviews with staff members.

This order must be complied with by

December 20, 2024

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must:

1. Ensure that a specified Registered Nurse is provided with re-training on the home's policy of zero tolerance of abuse and neglect, prior to them working their next shift in the home. A record must be kept of the date the training was provided, the contents of the training, and who provided the training.
2. Conduct a documented review of the allegation of abuse of a resident by another resident on a specified date. This review must be completed by at minimum the Administrator and Director of Care, or delegate, of the home and must document and address any deficiencies from the time of the incident related to the home's policy for zero tolerance of abuse and neglect.

Grounds

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with for three residents.

Summary and Rationale

A) A Critical Incident Systems (CIS) Report was submitted to the Director related to an allegation of abuse of a resident by another resident. A review of the clinical records for the victim indicated that there had been another incident of abuse by the same resident, which was not documented.

A staff member told an inspector that they had witnessed an incident of abuse between two residents and had reported it to a Registered Nurse at the time of the incident, after separating the residents. There was no documentation of the incident, no documented assessments of the victim related to the incident, and no CIS report submitted to the Director related to the incident.

The Director of Care (DOC) said they were unaware of the incident between the two residents, as the incident was not documented by staff or reported to management, and therefore was not investigated by the home. They said that a head to toe skin assessment should have been completed on the victim and a CIS report should have been submitted to the Director.

The home's policy titled " ADM-2-245 Abuse and Neglect" (Reviewed: August 2, 2023) stated that all allegations of abuse must document a note writing the details of the suspected, alleged or witnessed incident of abuse or neglect as soon as possible. The policy also stated that staff must investigate immediately all reports of abuse or neglect, in accordance with the investigation procedures set out in this document, that nursing staff must "conduct a head-to-toe physical assessment on the alleged victim and document findings if physical abuse is alleged." Furthermore, the policy stated that staff in the home must report the incident to the Ministry of Long Term Care Ministry Action Line Immediately.

There was a moderate risk of harm to a resident as a result of the staff in the home not complying with the home's policy to promote zero tolerance of abuse and neglect of residents.

Sources: Clinical records for two residents, and interviews with staff members.

B) A Critical Incident System report (CIS) was received by the Director regarding allegations of resident abuse and neglect.

During an inspection, the long term care home's (LTCH) policy "ADM 2-245 Abuse and Neglect" was reviewed and it stated “Any complaint/allegation of abuse will be investigated.”

The LTCH investigation file identified that a staff member recounted they did not follow the procedure from the policy, when it was reported to them that a staff member had reported allegations of staff to resident abuse. The staff member also said that when they became aware of an allegation of staff to resident abuse, they did not report, investigate, or document the allegations of staff to resident abuse.

When a staff member did not assess, investigate or report the allegations of staff to resident abuse, the resident did not immediately receive the treatment, care, services, or assistance required for their health, safety, or well-being.

Sources: Interview with a staff member; and record review of CIS investigation file, resident clinical records and LTCH policy ADM 2-245 Abuse and Neglect.

This order must be complied with by

January 3, 2025

COMPLIANCE ORDER CO #003 Skin and wound care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must:

1. Complete once weekly audits of all residents who are exhibiting altered skin integrity, to ensure that when clinically indicated an assessment is fully completed using a clinically appropriate assessment instrument, which was specifically designed for skin and wound assessment. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds

The licensee has failed to ensure that two residents, who exhibited altered skin integrity, received a completed skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:

A) A Critical Incident System report (CIS) was received by the Director concerning allegations of improper or incompetent treatment or care of a resident.

During a record review it was noted that when the resident was assessed, subsequent to receiving a complaint about allegations of staff to resident abuse, an assessment was completed, with areas of altered skin integrity identified. A section of the assessment stated " identify all skin observations that require further assessment.," however, no full assessments were completed for the two identified areas of altered skin integrity.

In an interview with the DOC, they acknowledged that the resident did not receive clinically appropriate skin assessments for areas of altered skin integrity.

When a resident was identified to have altered skin integrity, and a clinically appropriate assessment instrument specifically designed for skin and wound assessment was not completed, the resident was at risk for increased pain, impaired wound healing and the potential to decrease the resident's quality of life.

Sources: record review of Point Click Care assessment tab; interview with DOC

Summary and Rationale

B) An assessment was completed for a resident after there was an alleged incident of resident abuse. The assessment identified new areas of altered skin integrity. Upon review of the separate skin assessments there were multiple sections of each assessment where no response was documented.

During an interview with the home's Skin and Wound Care Lead, a Registered Practical Nurse (RPN), they stated that it was the expectation of the home that all sections of the assessment were completed. They said that the assessments for the resident were not completed as per the expectation of the home.

There was a low risk to the resident as a result of the skin assessments not being fully completed as per the expectations of the home.

Sources: Clinical records for a resident and interviews with an RPN.

This order must be complied with by

January 3, 2025

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.