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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2013	2013_226192_0005	L-000658-13	Complaint

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

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

MAPLE MANOR NURSING HOME
73 BIDWELL STREET, TILLSONBURG, ON, N4G-3T8

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

DEBORA SAVILLE (192)

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): August 28, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW)and the Resident Assessment Instrument (RAI) Coordinator.

During the course of the inspection, the inspector(s) reviewed resident census, medical records, and policy and procedure. Observed staff interaction with residents and the provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Interview with registered staff confirmed progress notes indicating that resident #001 used the specified chair when they became restless during the night shift. Interview also confirmed that the use of the specified chair was communicated verbally with some staff and was not included in the written plan of care.

The plan of care did not provide clear direction to staff and others who provide direct care to the resident in relation to the use of the specified chair for resident #001. [s. 6. (1) (c)]

2. The care set out in the plan of care for resident #001 was not provided to the resident as specified in the plan.

The plan of care for resident #001 related to restraints/safety devices indicates that resident #001 will have a tray table at all times when in the wheelchair, a seat belt at all times when in the wheelchair and a chair alarm in place on the wheelchair to monitor resident safety. Staff are to attend the alarm immediately if it sounds.

In August 2013 resident #001 was observed sitting in a wheelchair in front of the nursing station. The seat belt and tray table were in place but no chair alarm was observed on the wheelchair. Two staff confirmed that no chair alarm was in place while resident #001 was sitting in the wheelchair.

In August 2013 resident #001 sustained a fall from the wheelchair after removing the table top and seat belt. No chair alarm sounded at the time of this fall and it is unclear if the chair alarm was in place at the time of the fall.

The care set out in the plan of care was not provided to resident #001 in August 2013. [s. 6. (7)]

3. The licensee failed to 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.
c) care set out in the plan has not been effective.

Progress notes and staff interview confirm resident #001 was to be placed in the

specified chair when restless at night.

On two occasions in August 2013 the progress notes indicated that resident #001 was restless and climbing out of the specified chair.

On another occasion in 2013 the progress note indicated that the resident "was very agitated and restless and was sliding under the seat belt" of the specified chair.

Interview with registered staff confirmed that the effectiveness of using the specified chair had not been reassessed and was potentially increasing the risk of injury for resident #001.

The Director of Care confirmed the risk to the resident and had immediately initiated a reassessment of the use of the specified chair. [s. 6. (10) (c)]

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 ensuring that the care set out in the plan of care provides clear direction to staff and others who provide direct care to the resident; that care set out in the plan of care is provided to the resident as specified in the plan, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 10th day of September, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Debora Saville (192)