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 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
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 16, 2016	2016_323130_0024	029875-16	Complaint

Licensee/Titulaire de permis

1365853 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

MAPLE PARK LODGE
6 Hagey Avenue Fort Erie ON L2A 5M5

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

GILLIAN TRACEY (130)

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): December 6, 7, 9, 12, 13, 14, 15, 2016.

This inspection was conducted concurrently with the following Critical Incident inspections: 2016_323130_0025 / 028415-16, 030477-16.
During this inspection, staff, residents and families were interviewed, clinical records, relevant policies and procedure and critical incident reports, including the home's investigation notes were reivewed and residents were observed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Clinical Support Registered Practical Nurse (RPN), registered staff, personal support workers (PSWs), the Director of Care for Rose Hill Lane Inc., private duty support staff for Rose Hill Lane Inc., residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident.

A) A progress note recorded on a specific date in 2016, identified the need for resident #001 to have a safety intervention in place. The written plan of care was not updated to include this intervention, although at least three staff interviewed confirmed the intervention had been put in place. The RAI Coordinator confirmed the intervention was not added to the care plan while it was in use.

The plan of care for resident #100 did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A) Resident #001 sustained a fall with injury on an identified date in 2016. The resident returned from hospital the next day with post fall instructions from the Registered Nurse (RN), which was recorded in the progress notes. The following day, a written physician’s order provided contradictory instructions.

An assessment completed by the physiotherapist two days later, provided direction that was not consistent with either the hospital's instruction nor the physician's.

The DOC confirmed that the interdisciplinary team did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #001, stated that constipation was defined as "No BM (bowel movement) in three days". The Medical Directive indicated: on day three if no Bowel Movement give Dulcolax (i) tab (one tablet) or Milk of Magenesia 30 cc (cubic centimetres). If no BM, day four, give dulcolax suppository.

The resident’s bowel records were reviewed and revealed the resident had exhibited constipation on a number of specified dates in 2016.
Registered staff #100 confirmed that resident #001 was not administered a laxative on at least two occasions during the specified dates, to relieve symptoms of constipation, as specified in the Medical Directive.

Care was not provided to resident #001, as specified in their plan of care. [s. 6. (7)]

4. The licensee failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective,

that different approaches had been considered in the revision of the plan of care.

A) Resident #001 sustained falls with injury on two identified dates in 2016. The written plan of care was revised after each incident; however, the DOC confirmed that at least four fall prevention strategies, identified in the home's Falls Prevention and Management Program, CN-F-05-1, were not considered for resident #001, when the plan of care was revised.

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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; to ensure that care set out in the plan of care is provided to the resident as specified in the plan and to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) Resident #001 sustained a fall with injury on an identified date in 2016; however, the Post Fall Evaluation was not completed, using a clinically appropriate assessment instrument, until five days after the fall. The DOC confirmed the Post Fall Evaluation was required and was not completed using a clinically appropriate assessment instrument, after the resident sustained a fall with injury. [s. 49. (2)]

2. The licensee failed to ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) were readily available at the home.

A) On an identified date in 2016, registered staff #106 removed the safety intervention that was in use for resident #001 to use for a co-resident. Registered staff reported they removed the safety intervention from resident #001 because the resident had constant supervision in place; therefore the risk to the resident was minimal.

The RAI Coordinator confirmed resident #001 suffered no ill effects from the safety intervention being removed, on the identified date and also confirmed that there were no spare safety interventions available for use that shift.

Not all equipment, supplies, devices and assistive aids referred to in subsection (1) were readily available at the home. [s. 49. (3)]

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 when the resident has fallen, the resident is assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls and to ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

Issued on this 9th day of January, 2017

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

Original report signed by the inspector.