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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2017	2017_573581_0011	032876-16, 001790-17, 009950-17, 012310-17	Critical Incident System

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

DIANNE BARSEVICH (581), AILEEN GRABA (682)

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): July 27, 30, 31, August 1 and 2, 2017.

During the course of this inspection the following was completed concurrently:
Critical Incident Report
032876-16 related to falls prevention
009950-17 related to late reporting
012310-17 related to alleged abuse
001790-17 related to safe and secure home

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Nursing Department Assistant, Personal Support Workers and residents.

During the course of the inspection, the inspector reviewed residents’ clinical health records, observed provision of care, reviewed investigation notes, policy and procedures and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
8 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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

On an identified day in July, 2016, resident #002 fell and sustained an injury and a device was applied. Review of the physician orders dated on an identified day in July 2016, directed how and when the device was to be applied. Review of the plan of care revealed that the application of the device was not documented on the Personal Support Worker (PSW) flow sheets, Treatment Administration Record (TAR) or the written plan of care. Interview with RPN #104 confirmed the application of the device was planned care for the resident and was not documented in the written plan of care. [s. 6. (1) (a)]

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

A. Review of the plan of care identified that resident #002 fell on an identified day in July 2016 and sustained an injury and fell on an identified day in September 2016, with no injury. Review of the MDS assessment in September 2016, indicated they fell in the past 30 days; however did not identify they fell in the past 31 to 180 days and did not indicate they sustained an injury in the last 180 days. Interview with RPN #104 stated that the resident fell in the past 31-180 days and sustained an injury and confirmed the MDS assessment and the consultation reports were not integrated and consistent with each other.

B. Review of the plan of care revealed that resident #002 fell on an identified day in November 2016 and sustained an injury. Review of the MDS assessment in March 2017, identified they fell in the past 31 to 180 days but did not indicate they had an injury in the last 180 days. Interview and review of the MDS assessment and the clinical health record with RPN #104 and confirmed that the resident did fall and sustain an injury in the past 180 days and the MDS assessment and the Emergency Department Record were not integrated and consistent with each other. [s. 6. (4) (a)]

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 the planned care for the resident, that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation.)

Review of the registered nursing staffing schedule from April 17, to July 31, 2017, identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty on the following dates:
i. On May 19, 2017, on 12 hour night shift;
ii. On May 20, 2017, on 12 hour night shift;
iii. On July 16, 2017, on 12 hour night shift;
iv. On July 28, 2017, on 12 hour day and 12 hour night shift;
v. On July 29, 2017, on 12 hour night shift;
vi. On July 30, 2017, on 12 hour night shift.

Interview with the Nursing Department Assistant who completed the home’s staff scheduling stated there was RN agency staff in the building on the shifts listed above. The Administrator confirmed that the home was unable to staff those shifts with an RN who was an employee of the home. [s. 8. (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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation.), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

O.Reg. 79/10, s. 2 (1) definition includes sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On an identified day in May 2017, the home submitted a Critical Incident Report which indicated that on an identified day in May 2017, resident #011 was found in resident's #012 room having physical contact with resident #012. A review of the clinical records indicated that resident #012 had specific diagnoses related to cognitive impairment.

A review of the clinical records indicated that resident #011 had a specific test performed and received a score related to their cognitive abilities. They also had a known history of physical contact towards co-residents. On an identified day in May and three identified days in June 2017, documentation confirmed that resident #011 made inappropriate remarks towards resident #012.

On an identified day in May 2017, PSW #100 reported they witnessed an incident where resident #011 had physical contact with resident #012. PSW #100 stated they observed resident #012 awake and did not appear in any distress after the incident. PSW #100 identified they had provided care on several occasions to resident #012.

Interview with RN #105, who was identified as working on the identified date in 2017, confirmed they were notified by PSW #100 of the incident. RN #105 stated resident #012 was observed sleeping when they went to assess them after being notified by the PSW. RN #105 stated that interventions were put in place after the incident to protect resident #012 from any further contact by resident #011.

The Director of Care (DOC) and Administrator confirmed that resident #012 had a specific diagnosis and could not consent or had the capacity to consent to resident #011's physical contact and confirmed that the licensee failed to ensure that resident #012 was protected from abuse by anyone. [s. 19. (1)]

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 all residents were protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy, "Abuse-Prevention, Reporting and Elimination of Abuse and Neglect, (CA-05-37-1)", revised May, 2016, indicated, "The Administrator and/or designate must notify MOHLTC by phone immediately that an alleged, suspected or witnessed abuse or neglect has taken place or is likely to have taken place in accordance with the LTCHA and the reporting policy".

A. On an identified day in May 2017, the home submitted a Critical Incident Report, which indicated that on an identified day in May 2017, resident #011 was found in resident's #012's room having physical contact with resident #012. A clinical record review revealed that the incident occurred three days earlier and was not reported immediately to the Director. On an identified day in May 2017, PSW #100 reported that they witnessed an incident where resident #011 had physical contact with resident #012.

Interview with RN #105 confirmed they were informed by PSW #100 of the incident but denied being informed that PSW #100 observed physical contact between the two

residents. RN #105 stated they reported the incident to the oncoming RN but denied knowledge of contact between the residents.

The Director of Care (DOC) and Administrator confirmed that this witnessed incident should have been reported immediately and the home failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

B. On an identified day in May 2017, PSW #106 observed resident #011 in another resident's room having physical contact with resident #012. A review of clinical records indicated that resident #012 had specific diagnoses.

A review of the clinical records indicated that resident #011 had a specific test performed and received a score related to their cognitive abilities. The resident also had a known history of inappropriateness towards other residents. On an identified day in May and three identified days in June 2017, documentation confirmed that resident #011 made inappropriate remarks towards resident #012.

During an interview on an identified day in July 2017, PSW #106 confirmed that resident #012 had a specific diagnosis and could not consent or had the capacity to consent to resident #011's physical contact. PSW #106 confirmed that resident #011 had a known history of inappropriateness and had several incidents with resident # 012. PSW #106 reported that resident #011 was aware and apologetic when confronted. Resident #011 left the room without incident.

During an interview on an identified day in July 2017, RN #103 confirmed they assessed resident #012 following the incident, no concerns were observed. RN #103 confirmed that resident #012 had a specific diagnoses and could not consent or had the capacity to consent to resident #011's physical contact.

The Director of Care (DOC) and Administrator confirmed that the witnessed incident should have been reported immediately and the home failed to ensure that the written policy to promote zero tolerance of abuse was complied with. [s. 20. (1)]

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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31.

A. During the course of this inspection, resident #002 was observed seated in a wheelchair with a specific device applied. Review of the plan of care identified they required the device as a restraint due to risk for falls and safety and there was no restraint assessment completed that included alternatives when the device was initially applied. Interview with RPN #104 stated that the resident required the device as a restraint; however, confirmed there was no initial restraint assessment completed that included alternatives to restraining had been considered and tried prior to the resident being restrained with the device.

B. On an identified day in August 2017, resident #010 was observed in their wheelchair with a device applied. Review of the plan of care did not identify the resident was assessed for the device to be applied when up in the wheelchair. Interview with PSW #113, stated that they applied the device in error, the resident did not require the device and they could not remove the device independently. PSW #113 confirmed that the resident was not assessed for a restraint and that the device should not of been applied. [s. 30. (1) 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 no resident of the home is restrained by the use of a physical device, other than in accordance with section 31, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee failed to ensure that no device provided for in the regulations was used on a resident, to restrain the resident.

O. Reg. 79/10, s. 112. 6 identifies that the following devices are not used in the home which includes any device that cannot be immediately released by staff.

Review of the manufacturer's instruction outlined specific steps on how to apply and remove the device.

A. On an identified day in August, 2017, resident #009 was observed positioned in the wheelchair with a specific device applied. Review of the plan of care indicated they required the device as a restraint to prevent falls. Interview with PSW #113 stated the resident required the device as a restraint and was unable to remove the device independently. They demonstrated to remove the device, the wheelchair needed to be in a specific position and specific steps were required to remove the device off the wheelchair.

Resident #009 was observed by the DOC, RPN #110 and inspector #581 with the specific device applied and RPN #110 tried to remove the device. They first attempted to remove the device and were unable to do so. Then they made one adjustment to the device and were still not able to remove the device. PSW #114 came into the room and stated to remove the specific device, the wheelchair needed to be in a specific position, they placed the wheelchair in the position and made another adjustment to the device and removed it successfully. This task took approximately three to four minutes.

B. On an identified day in August, 2017, resident #008 was observed in a wheelchair with identified features and a specific device applied. Review of the plan of care identified they required the device as a restraint for safety due to a history of falls, as they were unable to remove the device independently. Interview with RN #103 stated the resident required the device as a restraint and were unable to remove it independently. They stated to remove the device, specific adjustments needed to be applied by the staff.

C. On August 2, 2017, resident #007 was observed in a wheelchair with identified features and a specific device applied. Review of the plan of care identified they required

the device as a restraint when up in the wheelchair to prevent falls. Interview and observation of the removal of specific device with PSW #114 stated the resident was unable to remove the device independently and it was removed by staff; however stated that the device could not be immediately removed by staff as specific adjustments needed to be applied to the device in order to remove it.

Interview with the DOC and RPN #110 and review of the manufacturer's instructions indicated the device was removed by making specific adjustments to parts of the device and stated the staff did not remove the device that way as it would agitate the residents. They identified that the specific device was applied as a restraint for all three residents as identified above and staff were not able to release the device immediately. They stated the home would no longer used that specific device to restrain residents if the device had to be applied and removed over a specific part of the wheelchair.

The DOC and RPN #110 confirmed the specific device would no longer be applied for resident #007, #008 and #009 as it was a prohibited device as the staff were not able to release the device immediately. [s. 35. (a)]

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 no device provided for in the regulations is used on a resident, to restrain the resident. O. Reg. 79/10, s. 112. 6 identifies that the following devices are not used in the home which includes any device that cannot be immediately released by staff, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

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

Review of the home's, "Falls Prevention and Management Program, CN-F-05-3" and "Head Injury Routine (HIR) Policy CN-H-01-1", identified that when a resident falls, witnessed or not witnessed they would be assessed by the registered staff including but not limited to vitals, neurological vitals, head to toe assessment and this would be documented in Point Click Care. The policy also indicated that due to the danger of intracranial complications following a head injury that all residents would have a HIR completed for a period of 48 hours and the HIR would commence even when the resident returned from the hospital based on the following timing. Vitals every 15 minutes for the first hour, every hour for the next three hours, every four hours until the 48 hour period from time of injury had elapsed.

Resident #002 had a witnessed falls on an identified day in July 2016 and sustained an injury and was sent to hospital and returned several hours later to the home with two injuries. Review of the plan of care identified that the HIR was not completed when the resident returned from hospital. Interview with the DOC stated that the registered staff should of implemented the head injury routine when the resident returned to the home, every four hours for 48 hours post injury and confirmed this was not completed. The DOC stated that HIR post falls were part of the clinically appropriate assessment. [s. 49. (2)]

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 a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer’s instructions.

A. On an identified day in August 2017, resident #007 was observed seated in the wheelchair with a specific device applied incorrectly. Review of the manufacturer’s instructions directed staff on the application of the device. Review of the plan of care identified they required the device as a restraint. Interview with RPN stated that the resident was unable to remove the device independently and was assessed as a restraint. They confirmed that the device was not applied correctly according to the manufacturer's instructions.

B. On an identified day in August 2017, resident #002 was observed seated in a wheelchair with a specific device applied incorrectly. Review of the manufacturer’s instructions identified that the device would be applied in a specific way. Review of the

plan of care identified they required the use of the device as a restraint. Interview with RPN #112 stated that the resident was unable to remove the device independently and was assessed as a restraint. They confirmed that the device was not applied correctly according to the manufacturer's instructions.

C. Resident # 008 was observed seated in the wheelchair on an identified day in August 2017, with a specific device applied. Review of the manufacturer’s instructions identified how the device would be applied. Review of the plan of care revealed that they required the device as a restraint. Interview with RN #103 stated that the resident was unable to independently remove the device and it was applied as a restraint. They confirmed that the device was not applied correctly according to the manufacturer's instructions.

The above restraints were not applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and included every release of the device and all repositioning.

During the course of the inspection resident #002, #007 and #008 were observed in their wheelchairs with a specific device applied. Review of the plan of care identified they required the device as a restraint related to history of falls. Review of ConMed Restraint/PASD/ Restraining flow sheet documentation revealed that PSW staff were to document under four codes for restraint use as follows:
i. Restraint was applied.
ii. Resident was removed.
iii. Restraint was positioned.
iv. Restraint was checked.

Interview and review of the home’s restraint flow sheet with the DOC confirmed that there were no codes for the PSW staff to document the releasing of all physical devices including the specific device on the restraint flow sheet. DOC stated they would be updating the restraint flow sheet form to include the documentation of releasing of all physical devices used to restrain a resident. [s. 110. (7) 7.]

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 the restraining of a resident by a physical device under section 31 or 36 of the Act, is applied by staff in accordance with any manufacturer's instructions and that every use of a physical device to restrain a resident under section 31 of the Act is documented and included every release of the device and all repositioning, to be implemented voluntarily.

Issued on this 1st day of November, 2017

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

Original report signed by the inspector.