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 prévue 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2019	2019_575214_0027	005722-19, 011770-19, 016713-19	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

CATHY FEDIASH (214), GILLIAN HUNTER (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): August 29, 30, September 3, 4, 5, 6, 10, 11, 2019.

This inspection was conducted simultaneously with critical incident inspection (CIS) number (#) 2019_575214_0028 / 012938-19, 013600-19, 017599-19.

The following intakes were completed during this complaint inspection:

005722-19 - related to Personal Support Services.

011770-19 - related to medication.

016713-19 - related to admission and discharge; responsive behaviours.

PLEASE NOTE: a Voluntary Plan of Correction (VPC) related to Ontario Regulation 79/10, r. 53(4) (b), identified in a concurrent CIS inspection #2019_575214_0028 / 012938-19, 013600-19, 017599-19 (log #012938-19, CIS#2891-000011-19 and log#017599-19, CIS#2891-000018-19) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Behavioural Supports Ontario (BSO) staff; Nursing Unit Clerk; Registered staff; Personal Support Workers (PSW); residents and families.

During the course of the inspection, the inspector(s) reviewed complaints; resident clinical records; policies and procedures; staff training records; program evaluations; and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. PLEASE NOTE: The following non-compliance was identified during concurrent CIS inspection #2019_575214_0028 / 012938-19, 013600-19, 017599-19, and was issued in this report.

The licensee has failed to ensure that strategies developed to manage the responsive behaviours of resident #003, were implemented.

A) Resident #003 was admitted to the home on an identified date with a specified diagnoses.

A review of the resident's plan indicated the resident exhibited, identified responsive behaviours.

On an identified date, an assessment completed by RN #118, identified the need for a specified strategy as other strategies to manage the responsive behaviours had been ineffective. A review of identified documents indicated that the specified strategy was provided to the resident once on an identified date.

Interviews conducted with RN #114 and PSW's #116 and #117, confirmed the resident exhibited the identified responsive behaviours and that the specified strategy was not consistently implemented.

The DOC confirmed that the plan of care identified the need for the specified strategy and that it was not provided because the home did not have the means to fulfill this

strategy.

An interview with staff #119 confirmed they were not aware of the need to fulfill the specified strategy for resident #003.

Strategies developed to manage responsive behaviours for resident #003 were not implemented.

B) The licensee has failed to ensure that strategies were developed and implemented to manage the responsive behaviours of resident #006.

A review of clinical records, showed that resident #006 was admitted on an identified date with a specified diagnoses. The plan of care revised on a specified date, indicated the resident had a history of specified responsive behaviour. DOC #109 confirmed that a specified strategy was initiated for resident #006 on an identified date, as other strategy's to manage the behaviour had not been ineffective.

A review of resident #006's progress notes showed the following:

On a specified date and time, staff #102 and #103, observed resident #006 and resident #003 in a particular activity. A second incident occurred later the same day; resident #006 blocked an identified door with resident #003 in the room. Staff entered and removed resident #003, who demonstrated for staff an identified action that resident #006 had done. A third incident occurred later the same day; resident #003 was observed in an identified location with resident #006, in a specified manner and resident #006 performing an identified action.

Two days later, resident #006 was observed and was heard telling resident #003 to come to an identified location for a specified reason. Later the same day, resident #003 and #006 were observed in an identified activity.

On an identified date and time, front line staff found resident #110, laying in an identified location, calling for help. Resident #006 was standing beside them. Resident #110, was removed from the room and verbalized specified concerns to the staff.

The DOC confirmed in an interview that the specified strategy to manage responsive behaviors of resident #006 was not initiated until a specified date, after multiple incidents of identified behaviours had occurred. It was also confirmed that after the resident had

been assessed for the specialized strategy, further incidents of identified responsive behaviours occurred because the identified strategy was not implemented. [s. 53. (4) (b)]

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 strategies developed to manage the responsive behaviours of resident #003, are implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe techniques when assisting resident #002.

A CIS report was submitted to the Director on an identified date related to a fall with injury.

A review of Risk Management documentation in Point Click Care (PCC), indicated that PSW #106 was transporting the resident to an identified location; the resident put their feet down and sustained a fall with injury.

A review of a progress note that had been populated from the Risk Management section in PCC, indicated the same information for this incident.

During an interview with PSW #106, they indicated they were assisting the resident with an identified activity of daily living (ADL). The staff member indicated that a specified item was around the resident during the transporting to an identified location and that the item became caught and the resident put their feet down at the same time, resulting in the fall. The staff member indicated that a specified device had not been in use when they assisted the resident; however, had assisted the resident in the same manner many times before, without incident.

PSW #106 indicated that they should have used a different specified item to place around the resident and that following this incident, a specified device had been implemented for the resident.

During an interview with PSW #106 and the DOC on the same day, they indicated that safe techniques had not been used when assisting resident #002. [s. 36.]

Issued on this 1st day of October, 2019

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

Original report signed by the inspector.