Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2021	2020_704682_0016	020710-20, 024069-20	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

AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 14,15,16,17 and 23, 2020.

The following Critical Incident inspections were conducted with this inspection:
020710-20 related to prevention of abuse and neglect
024069-20 related to prevention of abuse and neglect

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

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed resident health records, investigation notes, staff training records, program evaluations, staffing schedules and policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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. (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 there was a written plan of care for a resident that sets out, the planned care for fall preventions.

A resident was observed with fall prevention interventions. A review of the resident's care plan did not include the observed fall interventions. A review of the resident's bedside guide included one of the fall prevention interventions but not the other.

A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated that the care plan and bed side guide were documents used by staff that identified resident needs and outlined the planned care for the residents. The PSW confirmed that the resident had both fall interventions and that only one of them was included in the bedside guide. The RPN confirmed that neither strategies were included in the care plan.

Sources: Resident's care plan, bedside guide, observations, interviews with staff [s. 6. (1) (a)]

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

The licensee's investigation notes and critical incident indicated that a resident had a change in health condition. Progress notes documented by the Registered Nurse (RN) did not include any assessments or any communication of findings to the medical team for further direction related to the resident's change in health condition. Investigation notes indicated the RN did not reassess the resident when their care needs changed or relieve the resident's symptoms during their scheduled shift.

Two PSW's had worked and observed the resident's change in condition, they indicated they reported the change to registered staff. A RN stated that when they arrived for their shift they observed the resident's change in condition and following their assessment identified that the resident required additional medical intervention. The Senior Administrator and Director of Care (DOC) both stated that they expected registered staff to complete an assessment.The Administrator and DOC indicated that registered staff determined clinical decisions and revised residents planned care based on assessments. The Administrator and DOC confirmed an assessment was not completed by the RN when the resident's health condition changed. The Administrator and DOC also stated that they expected the medical doctor to be informed of the resident's change in condition and plan of care revised. Because the resident was not reassessed when their care needs changed, the resident was placed at risk for clinical deterioration.

Sources: The licensee's investigation notes, CIS, resident's progress notes, interviews with staff, Senior Administrator, DOC [s. 6. (10) (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 there is a written plan of care for each resident that sets out, the planned care for each resident; to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, vital signs were documented.

A resident's health condition changed and the licensee's investigation notes identified that a RN obtained vital signs. A review of the resident's clinical record did not include documentation of any vital signs completed. The Senior Administrator, DOC and RN in an interview, confirmed that vital signs were not documented.

Sources: The licensee's investigation notes, CIS, interviews with staff, Senior Administrator, DOC [s. 30. (2)]

WN #3: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented : all reassessments, monitoring, including the resident’s response and every release of the device and all repositioning.

In accordance with section 31. (1) of the LTCHA, a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident’s plan of care.

A resident was ordered a restraint to prevent attempts of unsafe ambulation. The resident's restraining flow sheet that included monitoring every hour, repositioning every two hours and codes for the resident's responses was missing staff signatures.

The Nursing Clinical Support (NCS) confirmed that PSW staff were expected to sign the flow sheet once a resident's restraint was applied. The DOC confirmed documentation was missing related to the resident's restraint application and monitoring.

Sources: Resident's medical records, resident restraining flow sheet, interviews with DOC and Nursing Clinical Support [s. 110. (7)]

Issued on this 14th day of January, 2021

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

Original report signed by the inspector.