Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2021	2021_704682_0022	008507-21, 009242-21, 011101-21, 011558-21	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

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

This inspection was conducted on the following date(s): December 1, 2, 3, 6, 7, 8, 9, 10, 13, 2021.

The following Critical Incident inspections were conducted:
011558-21 related to nutrition and hydration
011101-21 related to responsive behaviours and prevention of abuse
009242-21 related to personal support services
008507-21 related to falls prevention

The following Complaint inspections were conducted concurrently:
016589-21 related to prevention of abuse, continence, personal support services and plan of care
016491-21 related to prevention of abuse

PLEASE NOTE:
A Written Notification (WN) related to LTCHA S.O. 2007, s.6 (1)c was identified in this inspection and has been issued in inspection report 2021_704682_0021 which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Director of Care (DOC), Clinical Nursing Manager (CNM), Nursing Department Assistant, Universal Health Care Aides/Screeners, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Infection Prevention
and Control (IPAC) lead, Niagara Region Public Health (NRPH) staff, Housekeeping and Residents.

During the course of this inspection, the inspector observed the provision of the care, IPAC practices and general cleanliness and condition of the home, reviewed relevant clinical health records, investigation notes, staffing schedules, meeting minutes, staff training records, program evaluations and policy and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
3 VPC(s)
1 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 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 failed to ensure that staff used safe positioning techniques when assisting a resident while in a wheelchair.

A resident was transported in their wheelchair by a personal support worker (PSW). While in transit the resident sustained an injury. The resident's plan of care indicated that they required assistance on and off the unit.

The PSW confirmed that the resident required assistance at that time of the incident. The Clinical Nursing Manager (CNM) acknowledged that staff encouraged resident independence and foot rests were for situations when residents required assistance. They also confirmed that the PSW did not use safe positioning as this resident would have required the use of foot rests on their wheelchair when being transported in their wheelchair. Because the PSW did not safely position the resident while assisting and transporting them in their wheelchair, the resident sustained an injury.

Sources: CIS, resident electronic medical record (EMR), Interviews with PSW, CNM and other staff. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

The Chief Medical Officer of Health (CMOH) Directive #5 stated that individuals responsible for screening were to wear appropriate personal protective equipment (PPE) that protected their eyes, nose and mouth if they were within two metres of another person not wearing a mask or face covering in an indoor area and not separated by plexiglass or some other impermeable barrier.

The home's infection prevention and control (IPAC) resources included Provincial Infectious Diseases Advisory Committee (PIDAC) Routine Practices and Additional Precautions, In All Health Care Settings. This resource identified that where infection risks to staff and residents cannot be eliminated, engineering controls and/or physical measures such as plexiglass were the preferred choice for controlling the risk of infection.

A screener was observed to be less than two metres of a visitor entering the home and not behind a physical barrier or wearing eye protection. At the time the visitor was not wearing a face mask while answering screening questions. The visitor also leaned in closer to the screener to show proof of COVID-19 vaccination. Further observations identified another screener had performed a point of care rapid antigen test without eye protection or physical barrier less than two metres of a visitor who was not wearing a mask.

Both screeners stated that they did not wear eye protection when screening visitors or performing rapid antigen tests. Niagara Region Public Health (NRPH) environmental inspector consultation confirmed that the screener's PPE included eye protection when plexiglass was not in place and they were within two meters of visitors in an indoor area. Failure to follow the additional precautions/practices of the screener's wearing eye protection put all residents residing in the home at increased risk of potential exposure to COVID-19.

The home did not minimize the transmission risk of COVID-19 for its residents when staff did not follow the IPAC measures set out in Directive #5 and PIDAC's Routine Practices and Additional Precautions resource implemented to protect residents in long term care homes from COVID-19.

Sources: CMOH's Directive #5 and Public Health Ontario, Technical Brief, IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspected or Confirmed 19, Provincial Infectious Diseases Advisory Committee (PIDAC) Routine Practices and Additional Precautions, observation of the screeners, interview with NRPH and other staff. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents

Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents implementing interventions.

A resident had a known history of responsive behaviours. An intervention was initiated to prevent responsive behaviours towards co-residents and staff. Two residents were involved in an altercation when the intervention should have been in place. A Registered Nurse (RN) documented that they witnessed the altercation and that the intervention was not in place.

The same resident was observed to be sitting in the common area with co-residents in close proximity. The intervention was observed to not be in place on different occasions during observations. The Director of Care (DOC) and CNM both acknowledged that the intervention was not in place. The resident was at risk for altercations and potentially harmful interactions with co-residents when the intervention was not implemented.

Sources: CIS, resident electronic medical record and care plan, staffing schedule, Interview with RN, CNM, the DOC and other staff. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection and prevention and control program (IPAC) related to hand hygiene.

The home's infection prevention and control (IPAC) resources included Provincial Infectious Diseases Advisory Committee (PIDAC) Routine Practices and Additional Precautions, In All Health Care Settings. This resource included links to Just Clean Your Hands, hand hygiene improvement program and PIDAC's Best Practices for Hand Hygiene in All Health Care Settings. These resources identified that hands of residents were to be cleaned before assisting with meals or snacks.

Observations of the lunch service in the dining room included four ambulatory residents that seated themselves and were served a beverage by dietary staff without immediate prior assistance with hand hygiene. A PSW was observed assisting a resident to the dining room from the hallway. The PSW seated the resident at a dining table and proceeded to provide the resident with a beverage. The PSW did not provide any assistance to the resident with hand hygiene.

The PSW acknowledged assisting residents with hand hygiene was an expectation and they did not assist residents with hand hygiene at the lunch service.

When staff failed to comply with the home's IPAC practices related to hand hygiene implemented to protect residents in long term care homes, residents were put at risk for the transmission of COVID-19 and other pathogens. [s. 229. (4)]

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 staff participate in the implementation of the infection and prevention and control program, to be implemented voluntarily.

Issued on this 21st day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AILEEN GRABA (682)
Inspection No. / No de l'inspection :	2021_704682_0022
Log No. / No de registre :	008507-21, 009242-21, 011101-21, 011558-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 21, 2021
Licensee / Titulaire de permis :	1365853 Ontario Limited 3700 Billings Court, Burlington, ON, L7N-3N6
LTC Home / Foyer de SLD :	Maple Park Lodge 6 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carole Jukosky

To 1365853 Ontario Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care	Ministère des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8	Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must comply with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:
1. Ensure that residents that use a wheelchair as their primary means of mobility are assisted and transported in their wheelchair with the application of foot rests when indicated; using safe positioning techniques.

a) Develop a process to ensure staff are aware when a resident requires the application of foot rests to their wheelchair for safe positioning with transportation.

b) Perform weekly audits to ensure residents who require assistance are safely positioned with the application of foot rests when being transported in their wheelchair by PSW staff.

c) Document the weekly audits and continue auditing until no further concerns arise with PSW staff transporting and assisting residents in a safe position while in their wheelchairs.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe positioning techniques when assisting a resident while in a wheelchair.

A resident was transported in their wheelchair by a personal support worker (PSW). While in transit the resident sustained an injury. The resident's plan of care indicated that they required assistance on and off the unit.

The PSW confirmed that the resident required assistance at that time of the incident. The Clinical Nursing Manager (CNM) acknowledged that staff encouraged resident independence and foot rests were for situations when residents required assistance. They also confirmed that the PSW did not use safe positioning as this resident would have required the use of foot rests on their wheelchair when being transported in their wheelchair. Because the PSW did not safely position the resident while assisting and transporting them in their wheelchair, the resident sustained an injury.

Sources: CIS, resident electronic medical record (EMR), Interviews with PSW, CNM and other staff. [s. 36.]
An order was made by taking the following factors into account:

Severity: A PSW transported a resident in a wheelchair using unsafe positioning techniques and the resident sustained a significant injury as a result.

Scope: This was an isolated case as no other incidents of unsafe positioning were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 36 and one written notification (WN) was issued to the home in the past 36 months.

(682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of December, 2021

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Aileen Graba

Service Area Office / Bureau régional de services : Hamilton Service Area Office