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
Jan 12, 2017	2016_575214_0026	028843-16, 032296-16	Complaint

Licensee/Titulaire de permis

Better Life LTC Inc.
19 Richvalley Crescent RICHMOND HILL ON L4E 4C8

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

MAPLE VILLA LONG TERM CARE CENTRE
441 MAPLE AVENUE BURLINGTON ON L7S 1L8

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

CATHY FEDIASH (214), YULIYA FEDOTOVA (632)

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 1, 6, 7, 8 and 9, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Assistant Director of Care (ADOC) /Resident Assessment Instrument (RAI) Coordinator; Food Service Manager; Life Enrichment Coordinator; Registered staff; Personal Support Workers (PSW); Dietary Aides; Recreation Aides; residents and families. During the course of this inspection, the Inspectors reviewed resident health records; reviewed policy and procedures; reviewed the home's Complaints binder; reviewed monthly activity and program calendars; observed meal service; observed the administration of medications.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Minimizing of Restraining
Personal Support Services
Recreation and Social Activities
Sufficient Staffing

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

4 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. (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).

Findings/Faits saillants :

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

A) A review of resident #200's current written plan of care indicated that they used an identified safety device while up in their identified mobility device. On an identified date in 2016, the resident was observed sitting in their mobility device in their room watching television. It was observed that the resident had not had their identified safety device applied.

An interview with PSW #053 and registered staff #064 confirmed that the resident had an identified safety device that was to be applied when they were in their identified mobility device. Both staff confirmed that the resident's identified safety device had not been applied as specified in the resident's plan as they had just assisted the resident with an identified activity of daily living and each staff member had thought the other staff had applied the identified safety device.

B) A review of resident #200's clinical record indicated that the resident was admitted to the home on an identified date in 2016. A review of the resident's admission medication orders indicated that they had been prescribed to continue taking an identified over-the-counter product and to use their own supply until finished.

A review of the E-MAR and the E-MAR progress notes for the identified over-the-counter product indicated for a specified period of 13 days in 2016, this product was not available to administer.

An interview with the DOC confirmed that the resident did not receive their identified over-the-counter product for a specified period of 13 days in 2016, as there was no supply in the home in which to administer from and that care was not provided to the resident as specified in their plan. [s. 6. (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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the program included, the development, implementation and communication to all residents and families of a schedule of recreation and social activities that were offered during days, evenings and weekends.

A review of the home's monthly activity calendars for a specified period of four consecutive months in 2016 was conducted. It was observed that the last scheduled program of the day was held at 1600 hours. An interview with the Life Enrichment Coordinator confirmed that the home had not developed a schedule of recreation and social activities that were offered during the evening hours in the home. [s. 65. (2) (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 the program includes, the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends, to be implemented voluntarily.

WN #3: 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, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) A review of resident #200’s current written plan of care indicated that they used an identified safety device while up in their identified mobility device. A review of the Point of Care (POC) documentation system was conducted for a specified period of three consecutive days in 2016 and indicated in the POC system that the resident's hourly checks of their safety device had not been documented, when in use.

An interview with PSW #053 on an identified date in 2016, confirmed that the resident was checked hourly when their identified safety device was in place. The ADOC/ RAI Coordinator confirmed that staff had not documented these checks as the POC documentation system had not been set up for staff to document these actions.

B) A review of resident #204’s current written plan of care indicated that they used an identified safety device while up in their identified mobility device. The resident’s plan of care also indicated that staff were to check the resident hourly when their identified safety device was in use. A review of the POC documentation system was conducted for a specified period of three days in 2016 and indicated in the POC system that the resident's hourly checks of their safety device had not been documented, when in use.

An interview with PSW #099 on an identified date in 2016 who was responsible for the resident's care that day, confirmed that the resident is checked every hour when their identified safety device is in use. The ADOC/ RAI Coordinator confirmed that staff had not documented these checks as the POC documentation system had not been set up for staff to document these actions.

C) A review of resident #205’s current written plan of care indicated that they used an identified safety device related to their risk of falling. A review of the POC documentation system was conducted for an identified period of three days in 2016 and indicated in the POC system that the resident's hourly checks of their safety device had not been documented, when in use.

The ADOC/ RAI Coordinator confirmed that staff had not documented these checks as the POC documentation system had not been set up for staff to document these actions. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of resident #200's clinical record indicated that the resident was admitted to the home on an identified date in 2016. A review of the resident's admission medication orders indicated that they had been prescribed to continue taking an identified medication that they had been prescribed prior to their admission to the home. Physician's orders identified to use their own supply until finished.

A review of the electronic Medication Administration Record (E-MAR) for an identified month in 2016, indicated that the resident had received this medication using their supply that had been brought from home. A review of the following months E-MAR and E-MAR progress notes indicated that for an identified period of six days in 2016, the medication was documented with an identified code on the E-MAR indicating that the medication was not found in the cart or medication room and that the medication was documented in E-MAR progress notes as not available. A review of the physician's orders indicated that on an identified date in 2016, an order was placed by the home and faxed to the pharmacy that identified the resident's own supply was completed and for the pharmacy to deliver the medication. A review of the resident's progress notes and an interview with registered staff #058 indicated that the resident's family had inquired on an identified date in 2016, if the resident's identified medication had come from pharmacy. Registered staff #058 called the pharmacy regarding the order on the same day. Progress notes indicated that the pharmacy was not able to identify this medication when the order was faxed. Progress notes indicated that the pharmacy did obtain information regarding this medication and that the prescription was sent on an identified date in 2016.

An interview with the DOC confirmed that the identified medication was not available for a specified period of seven days in 2016 and that drugs were not administered in accordance with directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.