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
Mar 12, 2020	2020_803748_0002	023997-19	Critical Incident System

Licensee/Titulaire de permis

Better Life LTC Inc.
147 Estate Garden Drive RICHMOND HILL ON L4E 3X8

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

EMMY HARTMANN (748)

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): March 2, 4, 5, 2020.

The following intake was completed in this Critical Incident Inspection (CIS):

Log #023997-19, Critical Incident System (CIS) #2408-000013-19, was an incident of a missing resident.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Life Enrichment Coordinator, Maintenance, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 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. 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 :

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

Log #023997-19, CIS #2408-000013-19, was an incident of a missing resident that was

reported to the Ministry of Long Term Care (MLTC).

Progress note documented on an identified date, by RN #111, indicated that resident #001, had responsive behaviours during the shift, and interventions were implemented by staff. The progress note identified that resident #001 was given a treatment at an identified time, which was effective for some time, but that the resident had a change, when a procedure in the home was held. The progress note identified that at an identified time, a phone call from the Halton Regional Police was received, informing the home that resident #001 had been found outside of the home, and that the resident had been transferred to the hospital.

A review of the home's evaluation form for the procedure, identified that a procedure was conducted at an identified location. The form was then evaluated by the Administrator. The comments from the Administrator on the form indicated that RN #111 was re-instructed regarding the timing of the procedure, and not to conduct the procedure prior to an identified time.

A review of the home's plan for the procedure, identified that the charge nurse was in charge of the procedure, and that they were to follow steps outlined on the evaluation forms, which stated for all residents to be accounted for, after the procedure.

During an interview with RN #111, they confirmed that they were the charge nurse that worked on an identified date, and shift, and that they conducted the procedure. They identified that they did not do a formal head count of all residents after the procedure, to ensure that all residents were accounted for. RN #111 also identified that they were unaware that they should not have completed the procedure, before a certain time, but was informed of the expectation, after the incident.

During an interview with the DOC, they verified that resident #001 was found by the police outside of the home, who then transferred resident #001 to the hospital. The DOC identified that they completed an investigation into this incident, and found that RN #111 did not complete a head count after the procedure, to ensure that all residents were safe and accounted for, and that they conducted the procedure, before an identified time.

The home failed to ensure that the home was a safe and secure environment for resident #001.

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 #2: 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. (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 :

The licensee failed to ensure that resident #001's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Log #023997-19, CIS #2408-000013-19, was an incident of a missing resident that was reported to the MLTC.

Progress note documented, by RN #111, indicated that resident #001, had responsive behaviours during the shift, and interventions were implemented by staff. The progress note identified that resident #001 was given a treatment at an identified time, which was effective for some time, but that the resident had a change, when a procedure in the home was held. The progress note identified that at an identified time, a phone call from the Halton Regional Police was received, informing the home that resident #001 had been found outside of the home, and that the resident had been transferred to the hospital.

Progress note documented on an identified date, by RN #116, indicated that resident #001 returned to the home during the shift, at an identified time, and that the resident received a specific treatment at the hospital.

During a review of resident #001's written plan of care, it was identified that the resident had a high risk responsive behaviour, and an intervention for the behaviour was initiated on an identified date. It also identified to document the intervention on a specific form.

During an interview with RPN #116, a review of the resident's chart was completed with the inspector. RN #116 verified that an intervention for the high risk responsive behaviour was initiated for the resident, but they could not find the form, where the intervention was documented.

During an interview with ADOC #102, they identified that the intervention was initiated for the resident after they returned from hospital, on an identified date, and that it was only intended to be completed for a certain time, after the resident's return from the hospital. The ADOC identified that the resident's plan of care was not updated to reflect this.

During an interview with the DOC, they acknowledged that resident #001's plan of care should have been reviewed and revised, when the intervention was discontinued.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents, could not be opened more than 15 centimetres (cm).

Log #023997-19, CIS #2408-000013-19, was an incident of a missing resident that was reported to the MLTC.

During an observation of the resident home areas, on an identified date , the inspector identified windows on the first floor, that could open more than 15 cm. Two windows in the resident areas opened to 18 cm, and one opened to 36 cm.

During interviews with Life Enrichment Coordinator #104, and Maintenance #107, they confirmed that the areas the windows were located, opened to the outdoors, and were accessible to residents; and that the windows could be opened more than 15 cm.

During an interview with the DOC, they acknowledged that the windows should not be able to open more than 15 cm.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

The licensee failed to ensure that a written record was created and maintained for resident #001.

Log #023997-19, CIS #2408-000013-19, was an incident of a missing resident that was reported to the MLTC.

Progress note documented on an identified date, by RN #111, indicated that resident #001, had responsive behaviours during the shift, and interventions were implemented by staff. The progress note identified that resident #001 was given a treatment at an identified time, which was effective for some time, but that the resident had a change, when a procedure in the home was held. The progress note identified that at an identified time, a phone call from the Halton Regional Police was received, informing the home that resident #001 had been found outside of the home, and that the resident had been transferred to the hospital.

During a review of resident #001's written plan of care, it was identified that the resident had a high risk responsive behaviour, and an intervention for the behaviour was initiated on an identified date.

During an interview with RPN #116, a review of the resident's chart was completed with the inspector. RN #116 verified that an intervention for the high risk responsive behaviour was initiated for the resident, but they could not find the form, where the intervention was documented.

During an interview with ADOC #102, they identified that the intervention was initiated for the resident after they returned from hospital, on an identified date, and that it was only completed for a certain time, after the resident's return from the hospital. ADOC #102 identified that the intervention was documented, at the time, on a form, as per resident #001's written plan of care. However, ADOC #102 indicated that they were unable to locate the form, where the monitoring was documented.

During an interview with the DOC, they acknowledged that the form, where resident #001's intervention for the high risk responsive behaviour, was documented, should have been in the resident's records.

Issued on this 21st day of May, 2020

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

Original report signed by the inspector.