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 le Loi de 2007 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 17, 2017;	2016_271532_0023 (A2)	029180-16	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

THE MAPLES HOME FOR SENIORS
94 William Street South P.O. Box 400 Tavistock ON N0B 2R0

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

NUZHAT UDDIN (532) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 17 day of January 2017 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : NUZHAT UDDIN (532) - (A2)

Inspection No. / No de l'inspection : 2016_271532_0023 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 029180-16 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 17, 2017;(A2)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : THE MAPLES HOME FOR SENIORS
94 William Street South, P.O. Box 400, Tavistock, ON, N0B-2R0

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JOAN HERGOTT

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A2)
The licensee must ensure that care set out in the plan of care for the identified resident is provided to the resident as specified in the plan.
That care plan interventions for the identified resident are provided to ensure that the resident meets their target intake in a 24 hour period.

Grounds / Motifs :

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

An identified resident's plan of care, under eating was reviewed and it indicated that the resident was at high nutritional risk and that they required supervision and cueing. The identified resident's plan of care further stated the resident's daily calculated individual fluid needs and it indicated an identified amount that was offered in total at meals and snacks from the menu for the resident to choose from or to be offered daily. Plan of care also indicated that staff were to offer additional fluids daily and monitor for signs & symptoms of dehydration as per Hydration Program and double fluid at snacks. In addition to this the plan identified the resident was at

high risk for dehydration due to fluid output exceeding intake characterized by fluid volume deficit. Staff were to record intake in millilitres (mls) for all meals and snacks. Staff were to report any signs of dehydration and to refer resident to the Dietitian for evaluation and recommendations as clinically indicated and per policy and procedure.

Documentation by the Dietitian indicated that the identified resident was at high nutritional risk. The Dietitian documented that the fluids needs were adjusted to realistic goal and current fluid intake average. Staff were to encourage fluid intake at meals, snacks, and fluid watch and monitor for signs and symptoms of dehydration.

The Dietitian documented that the identified resident had signs and symptoms of dehydration and consumed less than the required amount. She further documented that the resident was offered fluids at additional fluid watch times during the day.

Meal observation and an interview with the staff revealed that the staff member gave the identified resident one drink and that they had not offered the second fluid at snack as stated in the plan of care. It was noted that approximately half of the offered three cups of fluids for the identified resident was wasted at the end of the meals.

A review of the fluid monitoring records from an identified dates, showed that the resident only achieved the minimum targeted intake in a 24 hours period on two different identified dates.

A review of the documentation for fluid watch showed that there were identified days where the identified resident was not offered additional fluids on each shift. In addition to this there were identified days where entry showed that despite being offered the fluids the resident refused and there was documentation to indicate not applicable under the fluid watch.

The DOC stated that if a resident was on a fluid watch the expectation was that staff offer additional fluids throughout the day. She stated that the dietitian or dietary manager would communicate to staff via the plan of care what the target amount of fluid would be. When asked what the expectation was for a resident who was to be provided double fluids at snack she said then staff should offer additional fluids through the day. PSWs were to record the resident's intake in POC. With respect to supplements she stated that sometimes the nurse leaves the supplement to be taken with the resident's meal. It was expected that the PSW would inform the registered

staff as to whether the resident took the supplement.

The scope was determined to be isolated to this one resident, the severity was actual harm as the resident was at high nutritional risk only achieving the minimum targeted intake in a 24 hour period twice in the month and there was a a history of previous unrelated non-compliance. (659)

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

Mar 31, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17 day of January 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NUZHAT UDDIN - (A2)

Service Area Office /
Bureau régional de services : London

Ontario

Ministry of Health and Long-Term Care

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Licensee/Titulaire de permis

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THE MAPLES HOME FOR SENIORS
94 William Street South P.O. Box 400 Tavistock ON N0B 2R0

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

NUZHAT UDDIN (532) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 24, 25, 26, 27, 28, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Manager, Director of Programs, Director of Food and Nutritional Services, Dietitian, Resident Assessment Instrument (RAI) Coordinator, Registered Nurse, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, Family and Residents' Council Representatives, residents and family members.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interactions, dining services, medication administration, medication storage areas, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Family Council

Infection Prevention and Control

Medication

Nutrition and Hydration

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

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

- **3 WN(s)**
- **1 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	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. 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 :

(A2)
1. The licensee has failed to ensure that care set out in the plan of care provided to the resident was provided to the resident as specified in the plan.

An identified resident's plan of care, under eating was reviewed and it indicated that the resident was at high nutritional risk and that they required supervision and

cueing. The identified resident's plan of care further stated the resident's daily calculated individual fluid needs and it indicated an identified amount that was offered in total at meals and snacks from the menu for the resident to choose from or to be offered daily. Plan of care also indicated that staff were to offer additional fluids daily and monitor for signs & symptoms of dehydration as per Hydration Program and double fluid at snacks. In addition to this the plan identified the resident was at high risk for dehydration due to fluid output exceeding intake characterized by fluid volume deficit. Staff were to record intake in millilitres (mls) for all meals and snacks. Staff were to report any signs of dehydration and to refer resident to the Dietitian for evaluation and recommendations as clinically indicated and per policy and procedure.

Documentation by the Dietitian indicated that the identified resident was at high nutritional risk. The Dietitian documented that the fluids needs were adjusted to realistic goal and current fluid intake average. Staff were to encourage fluid intake at meals, snacks, and fluid watch and monitor for signs and symptoms of dehydration.

The Dietitian documented that the identified resident had signs and symptoms of dehydration and consumed less than the required amount. She further documented that the resident was offered fluids at additional fluid watch times during the day.

Meal observation and an interview with the staff revealed that the staff member gave the identified resident one drink and that they had not offered the second fluid at snack as stated in the plan of care. It was noted that approximately half of the offered three cups of fluids for the identified resident was wasted at the end of the meals.

A review of the fluid monitoring records from an identified dates, showed that the resident only achieved the minimum targeted intake in a 24 hours period on two different identified dates.

A review of the documentation for fluid watch showed that there were identified days where the identified resident was not offered additional fluids on each shift. In addition to this there were identified days where entry showed that despite being offered the fluids the resident refused and there was documentation to indicate not applicable under the fluid watch.

The DOC stated that if a resident was on a fluid watch the expectation was that staff offer additional fluids throughout the day. She stated that the dietitian or dietary manager would communicate to staff via the plan of care what the target amount of fluid would be. When asked what the expectation was for a resident who was to be provided double fluids at snack she said then staff should offer additional fluids through the day. PSWs were to record the resident's intake in POC. With respect to supplements she stated that sometimes the nurse leaves the supplement to be taken with the resident's meal. It was expected that the PSW would inform the registered staff as to whether the resident took the supplement.

The scope was determined to be isolated to this one resident, the severity was actual harm as the resident was at high nutritional risk only achieving the minimum targeted intake in a 24 hour period twice in the month and there was a a history of previous unrelated non-compliance.

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

A) An identified room and bed observation revealed that a personal assistive device (PASD) was noted to be loose, creating a gap.

B) Another identified room observation revealed that the personal assistive device was loose when pulled.

Director of Care (DOC) reviewed the preventative maintenance binder and was not able to find the requisitions for both of the loose PASDs.

The Environment Service Manager (ESM) acknowledged that the personal assistive device was not part of the quarterly or monthly preventative checklist and that they were not being inspected on a regular basis and recognized that a loose PASD could pose a potential risk for the resident.

The severity of this area of non-compliance was minimal harm with potential for actual harm. The scope was determined to be isolated as it was identified for two out of the 20 residents and there was a history of previous unrelated non-compliance. [s. 90. (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 procedures are developed and implemented to ensure that, all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol procedure, strategy or system instituted or otherwise put in place was complied with.

Policy called Monitored Medications - Individual Monitored Medication Record included that "staff should sign on the individual monitored medication record each time a dose was administered. Include the date, time, amount given, amount wasted, and new quantity remaining."

The narcotic controlled substances records were reviewed and it was noted that the monitored drug records did not match the actual number of monitored medication remaining for an identified resident.

In an interview Registered Practical Nurse (RPN) confirmed that she had not signed the monitored medication record for the medications administered for the identified residents.

The Director of Care (DOC) stated that the expectation was that if it was a controlled substance that staff should document this on the individual monitoring record once it was administered and the policy was not complied with when staff failed to sign the monitored medication record for the medications administered for the residents.

The severity of this area of non-compliance was minimal harm. The scope was determined to be isolated to the two residents. There was a history of previous unrelated non-compliance. [s. 8. (1) (b)]

Issued on this 17 day of January 2017 (A2)

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

Original report signed by the inspector.