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 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

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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
Dec 10, 2018	2018_591623_0014	007806-18, 007818-18	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Maplewood
12 Maplewood Avenue Box 249 BRIGHTON ON K0K 1H0

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

SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 20, 21 and 22, 2018

The following logs were inspected concurrently:
Log #007818-18 - Complaint - related to allegation of abuse.
Log #007806-18 - for Critical Incident Report (CIR) - allegation of abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), RAI Coordinator and residents.

In addition, the following were reviewed: clinical medical records, the licensee's internal investigation, staff education records, and related policies.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Relate to Log #007806-18 for CIR, and log #007818-18 related to a complaint

A complaint was submitted to the Director on a specific date. The complainant indicated the following had occurred:
- The complainant indicated that the police had been contacted as there was an alleged case of abuse towards resident #001. On a specified date and time, the SDM for resident #001 noted that there was a specific injury and reported this to the RN on duty.
- On the following day, the SDM noticed that there was another specific identified injury. This was also reported to the RN on duty.
- Two days after the initial injury was identified, RN #100 reported to the SDM that the alleged cause of the injury to resident #001 had occurred as a result of a specific incident involving resident #001 and a staff member. The complainant indicated that they spoken to the Administrator on a specified date, four days after the initial injury was discovered. The Administrator indicated there would be a review, but the complainant had not heard back.
- Six days after speaking with the Administrator, when the SDM was visiting resident #001, the resident was noted to have another specific identified injury. The SDM contacted the police and they have started an investigation. The Administrator of the home was also notified of the discovery that same day. The complainant indicated that this was new over the last 10 days, prior to this the home had always communicated any incidents to the SDM.

Review of the progress notes for a specific period, was completed by Inspector #623.

Review of the clinical medical records for resident #001, specifically, the plan of care was completed by Inspector #623. Specific precautions were identified to maintain skin integrity for resident #001. Specific responsive behaviours were also identified, which included possible triggers and interventions to reduce the risk of occurrence and to assist staff to manage if a situation should occurr.

On a specific date and time, during an interview with Inspector #623, PSW #103 indicated that with every care interaction, they are assessing each resident for any specific identified concerns. The PSW indicated that if a specific concern is identified, it is to be documented on an assessment assessment sheet (paper) and submitted to the RN or RPN for further assessment. PSW #103 indicated that resident #001 requires specific identified interventions at all times to provide care, due to specific identified responsive behaviours. PSW #103 indicated that staff are to use the stop and re-approach technique if a specific identified responsive behaviour occurrs.

On a specific date and time, during an interview with Inspector #623, PSW #104 indicated that when providing care to resident #001 they require specific identified interventions. Staff are to use the stop and go approach, if resident #001 is exhibiting a specific identified responsive behaviour. PSW #104 indicated that the written plan of care is available in the POC, that identifies specific care requirements.

On a specified date and time, during an interview with Inspector #623, RN #100 indicated that staff are to keep all families informed of any specific identified injuries, responsive behavoiurs and change in condition. Specific to resident #001, the registered nurse is to contact the SDM if the resident is exhibiting specific identified responsive behavoiurs. The staff are not to use the SDM as the first course of action, this is the last resort, as they do not want to exhaust the SDM by calling them all the time. RN #100 indicated that resident #001 has a physician's order to receive specific interventions prior to receiving specific care, but this is not always effective. Resident #001 will still occasionally exhibit specific responsive behaviours. RN #100 indicated that they were made aware of the specific injury on resident #001's, when the SDM informed the staff. RN #100 indicated that the cause of the injury could not be determined. Resident #001 does exhibit specific identified responsive behaviours and it is possible the action of the resident could result in an injury. RN #100 indicated that since the injury was identified, there has been education for all direct care staff that included expectations and interventions. All injuries are expected to be reported to the RN or RPN, all responsive behaviors are to be

reported to the RN or RPN. The RN or RPN are then responsible to document the information and inform the SDM. This had not always been the practice of staff, prior to the complaint that was received, related to resident #001. RN #100 indicated that with every care interaction, the PSW's are supposed to be assessing each resident for any specific identified areas of concern. This information is to be placed onto an assessment sheet with a description. The sheet is to be submitted to the registered staff, the registered staff are then expected to assess the area of concern identified and react appropriately, which includes informing the SDM. RN #100 indicated that they do not consistently receive these sheets, if reported, it is often a verbal report to the RN and the RN will then assess.

On a specific date and time during a telephone interview with Inspector #623 and PSW #101 regarding the incident that occurrence with resident #001 on a specified date. PSW #101 indicated that PSW #102 and PSW #101 were providing care resident #001 on that specific date. The resident attempted to stand up, lost their balance and fell back into the transfer device. The safety bar fell and struck resident #001 in an identified area. After they got the resident settled, PSW #101 indicated that they were going to report the incident but got sidetracked and they forgot to tell the RN #100. PSW #101 indicated that the incident was reported the next morning to RN #100. It was after the SDM had already seen the injury when PSW #101 remembered they had not reported the incident. PSW #101 indicated that they offered to help PSW #102 with care that day because resident #001 requires two staff as they can exhibit specific identified responsive behavoiurs. PSW #101 indicated that when a transfer device is used, there are always two people transfer for safety. PSW #101 indicated that they were unaware of any other injury to resident #001. PSW #101 indicated that the expectation of the home is that when an incident occurs, PSW staff are supposed to report immediately to the RN or RPN. This did not happen. The PSW is to tell the nurse and then the PSW fills out an incident report to explain what has happened, this is then given to the nurse. PSW #101 indicated that they filled a report out the following day and submitted it to the Administrator. PSW #101 indicated that following this incident, there was education for all nursing staff, to improve communication and to remind staff about the importance of reporting. Incidents are expected to be reporting immediately.

PSW #102 was unavailable for interview during this inspection.

On a specified date and time, during an interview with Inspector #623, the Administrator indicated that when the internal investigation was completed, the cause of the specific identified injury to resident #001 was undetermined. It had been previously identified that

resident #001 exhibited specific identified responsive behaviours. The resident is also a very "private" person and does not like being "exposed". As a result, staff allow the resident to remain covered as much as possible when care is being provided, and therefore did not identify a specific injury. The Administrator indicated that the injury on resident #001's specific area was determined to be the result of the late reported incident, after care had been provided, that resulted in the safety bar striking the resdient. The two PSW's present at the time, did not report this to the RN or RPN when the incident occurred. It was not until the following day when the SDM had inquired about the injury, that the PSW revealed what had taken place the day before. The Administrator indicated that the PSW staff should have reported the responsive behaviour and the incident at the time it occurred.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, when an incident occurred that was not reported, which resulted in unexplained injury to resident

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 by ensuring that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other, to be implemented voluntarily.

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.