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
Feb 5, 2020	2020_640601_0002	020246-19, 021831-19, 022666-19, 000094-20	Critical Incident System

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

KARYN WOOD (601)

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): January 13, 14, 15, 16, 17, 21 and 27, 2020.

The following intakes were completed in this Critical Incident Report (CIR) Inspection:

A CIR related to a medication incident.

Two CIRs related to a fall that resulted in an injury.

A CIR related to allegations of resident to resident abuse.

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

The inspector also reviewed resident health care records, the licensee's relevant policies and procedures, observed the delivery of resident care and services, including staff to resident, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (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 has failed to ensure that the care set out in the plan of care for resident #011 was provided to the resident as specified in the plan, related to fall prevention.

A Critical Incident Report (CIR) was submitted to the Director related to an incident which occurred on a specified date. According to the CIR, resident #011 had a fall that resulted in a specified injury.

A review of resident #011's plan of care for a specified period, by Inspector #601 related to risk for falls and mobility identified the resident was at risk for falls. Resident #011's written care plan had specified interventions related to fall prevention and mobility.

A review of resident #011's progress notes and post fall investigation reports, by Inspector #601 for a specified period, identified the resident had fallen a specified number of times and they did not have the required fall prevention interventions in place, as specified in the plan of care.

On a specified date and time, Inspector #601 and RN #104, RAI/CCC #121 observed that resident #011 did not have their specified fall prevention interventions in place. RN #104, RAI/CCC #121 indicated to Inspector #601 that resident #011 should have the specified fall prevention interventions in place, as specified in the resident's written care plan.

On a specified date and time, Inspector #601 and the Director of Care (DOC) observed that resident #011 did not have their specified fall prevention intervention in place. The DOC further indicated that resident #011 should have the specified fall prevention intervention in place, as specified in the resident's written care plan.

During separate interviews on specified dates, PSW #106, PSW #107, RN #104, RAI/CCC #121 and the DOC indicated to Inspector 601 that resident #011 was at high risk for falls.

A review of resident #011's post fall investigation notes by Inspector #601 identified the registered staff who assessed the resident after their falls documented that resident #011's fall prevention interventions specified in the resident's written care plan were not in place, when the resident fell on the specified dates.

During an interview on a specified date, the DOC indicated to Inspector #601 that when resident #011 fell on specified dates, the registered staff completed a post fall

assessment. The DOC further indicated the registered staff documented that resident #011's fall prevention interventions were not in place as specified in the resident's written plan of care, on the specified dates.

The licensee did not ensure the care set out in the plan of care for resident #011 was provided to the resident on the specified dates related to the resident not having the specified interventions in place, as specified in the plan as a fall prevention measure. [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 for residents is provided to the resident as specified in the plan related fall prevention, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 unless the drug was prescribed for the resident.

A Critical Incident Report (CIR) was submitted to the Director for medication incidents involving ten residents that received the wrong medication, on a specified date.

Inspector #601 reviewed the Medication Incident Reports for residents #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 completed by RPN #105, on the specified

date. RPN #105 documented they had discovered that the ten residents had received a specified medication on a specified date, instead of the prescribed specified medication.

Inspector #601 reviewed the Medical Directives for residents #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 and their Medication Administration Records (MARs) for a specified date and identified the physician had prescribed the specified medication for these residents. The physician had prescribed one dose of the specified medication. Inspector #601 identified that RN #102 and RPN #103 had documented on the residents MAR that residents #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 had received the specified medication, on the specified date. The following was documented on the residents MARs on the specified date regarding the administration of the specified medication:

-RN #102 documented on the resident's MAR that they had administered resident #001, #002, #003, #005, #007 and #010's specified medication.

-RPN #103, documented on the resident's MAR that they had administered resident #004, #006, #008 and #009's specified medication. RPN #103 was not available for interview.

During an interview on a specified date, RN #102 indicated to Inspector #601 that on the specified date, RN #102 and RPN #103 had administered resident #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 specified medication. RN #102 further indicated a medication incident occurred when the residents received the specified medication instead of the prescribed specified medication, on the specified date.

During an interview on a specified date, the Director of Care (DOC) indicated to Inspector #601 that there were two types of the specified medication available and both physicians had prescribed for residents to receive the specified medication. The DOC further indicated that on the specified date, residents #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 had received the specified medication instead of the prescribed specified medication.

The licensee failed to ensure that no drug was used by or administered to resident #001, #002, #003, #004, #005, #006, #007, #008, #009 and #010 unless the drug was prescribed for the residents, when the residents received the specified medication instead of the prescribed specified medication. [s. 131. (1)]

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 no drug was used by or administered to a resident unless the drug was prescribed for the resident, to be implemented voluntarily.

Issued on this 6th day of February, 2020

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

Original report signed by the inspector.