



**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**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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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
Feb 19, 2016	2016_263524_0003	033817-15	Complaint

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

MAPLE MANOR NURSING HOME
73 BIDWELL STREET TILLSONBURG ON N4G 3T8

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

INA REYNOLDS (524)

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): February 3, 2016.

This inspection is related to a complaint regarding plan of care interventions.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Assessment Instrument Coordinator and a family member.

The inspector also observed resident and staff interactions, reviewed the complaint, resident health records, staff education records and policies and procedures related to this inspection.

**The following Inspection Protocols were used during this inspection:
Responsive Behaviours**

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

3 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours



Specifically failed to comply with the following:

- s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
- (a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
 - (b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
 - (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

Findings/Faits saillants :

1. The licensee has failed to ensure that actions had been taken to meet the needs of a resident's behaviours which would have included assessments, reassessments, interventions, and documentation of the resident's responses to the interventions.

Review of the progress notes for an identified resident for a specified time frame, revealed numerous identified documented behaviour patterns. There was no documented evidence of assessment, reassessment, or revisions of interventions on approaches, techniques and suggestion from the multi-disciplinary team, and documentation of the resident's responses to the interventions.

Review of the most recent care plan revealed the behaviour care plan did not specifically address the needs of the resident. There was no assessment or reassessment of the identified behaviours, with written strategies, including approaches and techniques to care and interventions to prevent and respond to the resident's behaviours.

The Director of Care confirmed on February 3, 2016, that the home had failed to ensure that for each resident demonstrating behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (4) (c)]



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 actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

- 1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
- 2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
- 3. Behaviour management. 2007, c. 8, s. 76. (7).**
- 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
- 5. Palliative care. 2007, c. 8, s. 76. (7).**
- 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

Findings/Faits saillants :



1. The licensee has failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training related to behaviour management at intervals provided for in the regulations: O. Reg 79/10 s. 221 (2) 1: the staff must receive annual training in all areas required under subsection 76 (7) of the Act.

Record review of the mandatory training documents for 2015 with the Director of Care revealed 47 out of 94 (50%) of staff members had not received the mandatory annual training on behaviour management.

Staff interview with the Director of Care on February 3, 2016, confirmed not all staff who provided direct care to residents had received training in 2015 related to the mandatory education session on behaviour management. [s. 76. (7) 3.]

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 all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to behaviour management at intervals provided for in the regulations: O. Reg 79/10 s. 221 (2) 1: the staff must receive annual training in all areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

- s. 27. (1) Every licensee of a long-term care home shall ensure that,**
- (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**
 - (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**
 - (c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

Interview with a family member and review of an identified resident's clinical records revealed there was no documented evidence that a care conference of the interdisciplinary team was held within six weeks of admission to the home. The resident and/or substitute decision-maker were not given an opportunity to participate fully in a care conference to discuss the resident's care needs and other matters of importance.

This was confirmed by the Director of Care on February 3, 2016. The Director of Care confirmed the home's expectation was that a care conference was to be held within six weeks following the resident's admission to the home. [s. 27. (1) (a)]



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Issued on this 19th day of February, 2016

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

Original report signed by the inspector.