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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2018;	2018_523461_0002 (A1)	023197-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Maple Health Centre
10424 Keele Street Maple ON L6A 2L1

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

Amended by CRISTINA MONTOYA (461) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requested an extension of the Compliance Date to July 31, 2018.

Issued on this 28 day of June 2018 (A1)

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

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Amended by CRISTINA MONTOYA (461) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 9-12, 15-18, 2018

This inspection was completed concurrently with the following intakes:

Log #004908-17 (Follow Up), related to falls prevention program

Log #021781-17 (Critical Incident Report), related to alleged staff to resident abuse

Log #023509-16 (Critical Incident Report), related to unexpected death of a resident

Log #006529-17 (Complaint), related to resident's delayed assessments

Log #013116-17 (Complaint), related to medication management

During the course of the inspection, the inspector(s) spoke with the Administrator, interim Director of Care (DOC), Supervisors of Care (SOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Accreditation and Compliance Advisor, RAI Coordinator, Supervisor of Programs and Services, Support Services Clerk, Physiotherapist (PT), Registered Dietitians (RD), Personal Support Workers (PSW), Housekeeping Aids, Resident Council President, Families, and residents.

During the course of the inspection, the inspector(s) toured the long-term care home; observed staff to resident interactions and resident to resident interactions; reviewed clinical health records, Resident Council Minutes; reviewed licensee policies, specifically, Falls Prevention and Management Program, Personal Assistance Service Device, Administration of Drugs, Medication Incidents and Adverse Drug Reactions, Drug Records, Obtaining and Keeping Drugs, Receiving and Reporting Complaints, Zero Tolerance of Abuse and Neglect program; reviewed the home's investigations related to critical incident reports.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Resident Charges

Residents' Council

Safe and Secure Home

Skin and Wound Care

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

11 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 6. (7)	CO #001	2016_414110_0014	461

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 O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are not charged for goods and services that the licensee is required to provide to residents under agreement between the licensee and a Local Health Integration Network, specifically, fall protective devices.

Under Long-Term Care-Service Accountability Agreement (L-SAA) Policy: Long-Term Care Homes (LTCH) Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment: The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, including but not limited to: c. Equipment and supplies to ensure resident safety
d. Equipment and supplies to prevent resident falls

On an identified date, during an interview with the Physiotherapist (PT), the PT indicated to Inspector #461, when identified fall protective devices were recommended for resident's safety and prevention of injuries from falls, the families had to purchase the devices. The PT indicated the licensee directed the PT that the identified fall protective devices were personal devices and therefore purchased by the resident or families. The PT indicated that had recommended the identified fall protective devices for resident #007, and the family was in the process of purchasing the safety items. The PT also indicated that resident #004 was using the identified safety devices, which were purchased by the resident's family. The PT indicated there were eight additional residents using the identified protective device that were paid for by the family. These included residents #029, #030, #031, #033, #034, #035, #036, and #037.

Review of the progress notes for resident #007, indicated that RPN #115 sent a referral to the Occupational Therapist (OT) and Physiotherapist (PT) requesting the identified fall protective devices for the resident. The PT measured the resident #007 for the identified fall protective devices, and provided the family with information where they can purchase the devices.

Review of the progress notes for resident #004, the PT indicated that resident #004 should wear the identified fall protective device to prevent falls with injuries.

The family members of residents #007 and #004, indicated that the home asked them to purchase the identified fall protective devices. Resident #007's family member indicated that had been given the measurements to purchase the identified fall protective devices. Resident #004's family member said that bought a

set of protective devices for resident a long time ago when the nurse asked the family member to.

RPN #115 indicated to inspector #461 that when a resident needed the identified fall protective devices, the nursing staff and the PT had a discussion with the resident's family before implementing the interventions, as the family was required to purchase the mentioned protective devices.

The Administrator indicated that approximately seven years ago, the licensee decided to have families purchased the identified fall protective devices as they were considered personal devices and could not be reused on other residents. The families had been given a list of vendors outside the home; the home did not benefit financially from these purchases. The Administrator confirmed to Inspector #461 that the families of resident #004 and the other eight residents identified by the PT that were using the identified fall protective devices had to purchase the devices.

The licensee failed to ensure that the residents were not charged for goods and services that the licensee was required to provide to residents under an agreement between the licensee and a Local Health Integration Network, specifically, fall protective devices. [s. 245. 3.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 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.

Related to Intake #013116-17 for resident #023:

Resident #023's diagnoses included cognitive impairment and other identified health conditions. Resident #023 had a physician's order for an identified medication to be given daily.

The clinical health record for resident #023, was reviewed by Inspector #554 for approximately a three month period, indicating the resident had abnormal laboratory values. On an identified date, the physician reviewed resident's abnormal bloodwork, and suggested to repeat bloodwork in one week; and to reassess the identified medication in a month.

A family member submitted a written complaint to the Administrator with concerns

that included, why the identified medication had been stopped on an identified date.

The electronic medication administration record (eMAR) was reviewed, by Inspector #554, for a two and half month period. Resident #023 was not administered the identified medication for 41 days (approximately six weeks). The clinical health record for resident #023 did not contain a physician's order to hold or discontinue the identified medication.

The Registered Practical Nurse (RPN) #109, who worked in the home on the date the physician ordered the identified bloodwork, indicated to Inspector #554, that Registered Nurse (RN) #121 and RPN #109 transcribed the physician orders for resident #023 on the date the order was written. The RPN #109 indicated that a reminder for resident #023's physician to reassess the identified medication in one month, was written, by the RPN and placed into the Physician's Communication binder, for the physician to see the following week. The RPN #109 indicated that put a written notation on the eMAR for the identified medication to be reassessed on an identified date. The RPN #109 indicated being unaware if the physician reviewed the eMAR. The RPN #109 further indicated that it was up to the physicians to remind themselves, not the responsibility of registered nursing staff to remind physicians.

Registered Nurse #121 was not available for an interview during this inspection.

The Registered Practical Nurse (RPN) #115 indicated that the Weekly Resident List, in the Physician's Communication binders was only in place for a period of one week, and it was up to registered nursing staff to move communications regarding resident care, and or follow up's required onto the next week's list for the doctor to review, but indicated that this practice was inconsistent from registered nurse staff to registered nursing staff. RPN #115 indicated that there was no documented policy and or procedure surrounding alerting or reminding physicians of required reassessments.

The Attending Physician who wrote orders, for resident #023, was no longer providing medical service to the long-term care home, as per RPN #115 and the Supervisor of Care Registered Nurse #103.

The Supervisor of Care-RN #103 indicated that there was no policy, or procedure in place to alert physicians to review and or reassess a resident's medications,

laboratory values and or changes in a resident's health condition which were needed beyond a week at a time. The Supervisor of Care-RN #103 indicated that the responsibilities for reminding physicians week to week would be that of registered nursing staff working the resident home areas.

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 were integrated, consistent with and complement each other, specifically in the reassessment of resident #023's laboratory values and identified medication. [s. 6. (4) (a)] (554)

2. Related to Intake #006529-17 for resident #024:

Review of resident #024's health records indicated a physician's order for a diagnostic test on an identified date. A review of the progress notes for resident #024, indicated that a diagnostic test was ordered on an identified date, but the procedure was not completed until four days later.

The RPN #128 who worked on the date the physician ordered the identified test, was unavailable for an interview. The RPN #127 confirmed that worked on the date the second check of the physician's order was completed, but did not recall the identified diagnostic test being ordered for resident #024.

The DOC indicated to Inspector #461 that the registered staff were expected to process any physician's orders within 24 hours. The DOC confirmed that for resident #024's, the home did not have a tracking system to determine whether the diagnostic test provider received resident #024's test requisition or not.

Review of the health records for resident #024 and interview with staff confirmed that staff did not collaborate with each other to ensure that a diagnostic test that was ordered by the physician was completed. Resident #024 waited four days to have the test performed. [s. 6. (4) (a)] (461)

3. The licensee failed to ensure the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Intake #013116-17 for resident #023:

Resident #023's diagnoses included cognitive impairment and other identified health conditions.

Documentation in the clinical health record for resident #023, provided support that resident had a family member in place for care decisions.

The Registered Practical Nurse (RPN) #109, and Supervisors of Care-Registered Nurses #103 and #124, all indicated that the family member for resident #023 was involved on a daily basis with resident's care decisions.

In a written complaint, the family member for resident #023 indicated that was not notified of a change in resident's health condition.

The clinical health record for resident #023, was reviewed by Inspector #554 for approximately a three month period, indicating the resident had abnormal laboratory values. On an identified date, the physician reviewed resident's abnormal bloodwork, and suggested to repeat bloodwork in one week, and to reassess the identified medication in a month.

The Registered Practical Nurse (RPN) #109 indicated to Inspector #554, that they worked on the date the order was written. The RPN #019 indicated that RN #121 and RPN #109 did transcribe physician orders for resident #023 on the identified date. RPN #109 indicated that the family member for resident #023, was not updated of a change in resident's health condition.

Registered Nurse #121, who was the Charge Nurse on the date the physician's order was written, was not available for an interview during this inspection.

The clinical health record failed to provide documentation to support that resident #023's family member was notified of a change in resident's health condition, and or plans to monitor the abnormal laboratory values, following the physician's order.

The Supervisors of Care-Registered Nurses #103 and #124, both indicated registered nursing staff were to notify the Substitute Decision Maker of any change in a resident's health condition and or medications. Registered Nursing Staff failed to notify resident #023's family member of a change in resident's health condition. [s. 6. (5)] (554)

4. The licensee failed to ensure that the care set out in the plan of care was

provided to the resident as specified in the plan.

Related to Intake #023509-16 for resident #021:

Resident #021's diagnoses included an identified health condition.

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date and time, specific to the unexpected death of resident #021. The Coroner indicated the cause of death as being accidental.

Registered Nurses #101, #107, and the Supervisor of Care-Registered Nurse (SOC-RN) #124 indicated to Inspector #554, that resident had a change in condition that required hospitalization. RN #101 and SOC-RN #124 indicated that following return to the long-term care home, the physician had ordered to monitor an identified vital sign.

The clinical health record for resident #021, was reviewed by Inspector #554. The clinical health record contained physician's orders written on an identified date, specific to monitoring of an identified vital sign and application of an identified intervention. There was no order, written by a physician, for the orders to be discontinued.

Review of resident's progress notes, indicated that on an identified date, resident's identified vital sign was abnormal. There was no documentation of the actions taken by RN #101 or any other registered nursing staff for this date.

Review of resident's vitals in the electronic health record for a two month period, indicated the identified vital sign was recorded by registered nursing staff for resident #021, for seven days during the reviewed period.

The Registered Nurse (RN) #101 indicated to Inspector #554, that resident #021 was to have the identified vital sign monitored and maintained within a specified range. RN #101 indicated that if the vital sign was outside the specified range, then an intervention was to be applied. RN #101 indicated monitoring of the identified vital sign taken was to be recorded in either the progress notes or the vitals section of the clinical health record, and any action taken by registered nursing staff should be recorded in progress notes. RN #101 indicated that had not documented a follow up assessment on an identified date, as it was their belief that the shift was "busy".

The Supervisor of Care-RN #124 indicated to Inspector #554, the clinical health record did not consistently document that registered nursing staff were monitoring the identified vital sign of resident #021. The Supervisor of Care-RN #124 further indicated that on an identified date, RN #101 failed to document actions taken when resident #021's identified vital sign value was abnormal.

Registered Nurse #101 and other registered nursing staff failed to ensure that the care set out in the plan of care was provided to resident #021, specific to monitoring of an identified vital sign and taking actions when the vital sign values were abnormal, as specified in the plan.

At the time of this inspection, there was a Compliance Order under LTCHA, s. 6 (7). This Compliance Order was issued February 2017, under Inspection Report #2016_414110_0014. The order was to be complied by April 30, 2017. The identified non-compliance specific to resident #021 occurred prior to the compliance due date. [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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the residents so that their assessments are integrated, consistent with and complement each other; and to ensure that the care set out in the plan of care is provided to the residents as specified in the plan, 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 failed to ensure that any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place is complied with, specific to Medication Management.

Under O. Reg. 79/10, s. 114 (2) - The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee's policies, "Obtaining and Keeping Drugs" (#5) and "Drug Records" (#12) (both policies issued July 2013) directs that registered nursing staff shall:
General Procedures:
- Ensure that a clear, complete and signed physician's order exists, and includes the date, and time the order was written; resident's name, centre, and room number; drug form, drug dose; route for administration; frequency of administration; length of time for administration if applicable; any specific information related to previous orders, for example, discontinuing of previous dosage or related drug.
Receiving Medications from the contract pharmacy service provider:
- If any concerns exist regarding the packaging of the medication, registered nursing staff are to notify pharmacy.

The licensee's policy, "Obtaining and Keeping Drugs" further directs that if an order is not clear, registered nursing staff are to consult with the physician.

Related to Intake #013116-17 for resident #023:

Resident #023's diagnoses included an identified health condition.

Resident #023 had a physician's order for an identified medication to be given daily.

On an identified date, the Physician for the resident #023, wrote an order, directing registered nursing staff to have bloodwork to be taken in one week; encourage fluids; and to reassess identified medication in one month.

A review of the electronic medication administration record (eMAR), indicated that on the date the physician wrote the order, Registered Practical Nurse #109 and Registered Nurse #121 revised the eMAR, and indicated the order for the identified medication was to be administered for approximately one month. The eMAR indicated that the identified medication for resident #023 was last administered on an identified date. Resident #023 did not receive the physician's ordered identified medication for 41 days (approximately six weeks). There was no physician's order to HOLD and/or discontinue the identified medication.

There was no indication in the clinical health record, during the above identified dates, that registered nursing staff contacted the Physician for clarification of written medication order.

The SOC-RN #103 indicated to Inspector #554, that a family member questioned registered nursing staff as to why the medication had been stopped, why the medication was still being sent to the long-term care home for resident #023, and why the family member was still paying for a medication that was not being administered to resident #023.

The SOC-RN #103 indicated that the licensee's investigation of the medication incident identified the following:
- The physician prescribed the identified medication to be administered daily at an identified time. There was no physician's order for this medication to be held or discontinued. On an identified date, the physician for resident #023, ordered bloodwork to be drawn in one week, encourage intake of fluids, and to reassess the identified medication in one month.
- The eMAR dated on an identified date, indicated that the medication order was only to be administered until a specified date. The identified medication order, was revised on an identified date, by the Registered Practical Nurse #109. The order

was incorrectly transcribed.

- The identified medication for resident #023 was being sent weekly by the contracted pharmacy service provider to the long-term care home. The identified medication was sent from pharmacy on a weekly basis, in the medication strip packages. The medication strip package was identified as being for resident #023, to be administered daily. The Supervisor of Care-RN #103 indicated that registered nursing staff were signing for receipt of the identified medication every week for approximately six weeks, but resident #023 did not receive the medication.

- The SOC-RN #103 indicated that at least nine different registered nursing staff had administrated medications to resident #023 during the identified six-week period. The SOC-RN #103 indicated that none of the identified registered nursing staff had questioned the discrepancy between the medication being sent by the contracted pharmacy provider, the eMAR, and or the physician's order for the identified medication.

The RPN #109 indicated to Inspector #554, that was the full-time nurse on the resident home area where resident #023 resided. A review of the eMAR provided support that RPN #109 worked 21 times, and administered medications to residents, including resident #023, during the six-week period that resident did not receive the identified medication. RPN #109 could not recall contacting the pharmacy service provider as to why the identified medication was being sent in the medication packaging strips for resident #023, nor could she recall contacting the physician specific to the identified medication order.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place is complied with, specific to Medication Management for resident #023. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place is complied with, specific to Medication Management, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a resident-staff communication and response system available in every area accessible by residents.

On an identified date, during a tour of the long-term care home it was observed, by Inspector #554, that there was no resident-staff communication response system available in the following areas:

- Main Lobby-Sitting Lounge
- Town Hall

- Fireplace/Aquarium Lounge

All three areas were located on the ground floor of the long-term care home. During the observation, residents were observed in the Main Lobby-Sitting Lounge, and in the Fireplace-Aquarium Lounge without staff in attendance.

The Supervisor of Programs and Support Services indicated to Inspector #554, that all three areas were accessible to residents residing in the long-term care home. The Supervisor of Programs and Support Services indicated that there was no resident-staff communication response system available in the identified areas. The Supervisor of Programs and Support Services indicated that if a resident needed assistance they would have to wait until staff came by the identified areas to assist them.

On an identified date, Inspector #554 observed a scheduled activity program occurring in a room on the ground floor, there were approximately twelve residents in attendance. Inspector #554 further identified that there was no resident-staff communication response system accessible in this room. A staff member facilitating the program indicated, to Inspector #554, that the program was a scheduled activity. The staff member indicated that there was no resident-staff communication response system available in the room, and that the room was used at minimum weekly by residents.

The Administrator indicated, to Inspector #554, that was not aware that the identified areas did not have a resident-staff communication and response system accessible to residents.

The licensee failed to ensure that there was a resident-staff communication and response system available in every area accessible by residents. [s. 17. (1) (e)]

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 there is a resident-staff communication and response system available in every area accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, or may occur, immediately reports that suspicion and the information upon which it was based to the Director.

Related to Intake #021781-17 for resident #022:

The Supervisor of Care-Registered Nurse (SOC-RN) #103 submitted a Critical Incident Report (CIR) to the Director, on an identified date and time, related to an

alleged incident of staff to resident physical abuse, involving resident #022. The alleged abuse was reported to the Director three days after the alleged abuse was reported by resident #022.

The CIR provided the following details, of the alleged abuse:

- Resident #022 indicated to the Registered Nurse (RN) #125, on an identified date and time, that had been physically abused by an unspecified individual. Resident #022 indicated to RN #125 that was afraid that the individual would return to their room and cause further harm. The CIR indicated that resident #022 had bruises on identified body parts.

During an interview, RN #125, who was the Charge Nurse on duty on the identified date of the alleged abuse, indicated to Inspector #554, that resident #022 indicated that had been physically abused by an individual. The RN #125 indicated that resident had bruising on identified body parts. RN #125 indicated that reported the alleged abuse and injuries to the On-Call Manager; RN #125 indicated that the On-Call Manager was SOC-RN #103. RN #125 indicated that did not report the alleged abuse to the Director, as such was reported to the SOC-RN #103, and further indicated had not been directed to report the allegation to the Director. The RN #125 indicated being aware that alleged, suspected or witnessed abuse was to be immediately reported to the Director.

The Supervisor of Care-Registered Nurse (SOC-RN) #103 indicated to Inspector #554, that was aware of the alleged staff-resident abuse, which had been reported to RN #125, by resident #022. The SOC-RN #103 indicated that RN #125 was the Charge Nurse on the identified date, the allegation of abuse was reported, and the SOC-RN was the On-Call Manager. The SOC-RN #103 indicated that had not reported the abuse allegation to the Director, nor had directed RN #125 to report the alleged abuse of resident #022.

The SOC-RN #103 indicated being aware that alleged, suspected and or witnessed abuse of a resident was to be immediately reported to the Director. The SOC-RN #103 indicated that the alleged abuse had not been immediately reported as the allegation was being investigated prior to reporting it.

The Supervisor of Care-Registered Nurse #103 and Registered Nurse #125 failed to immediately report an allegation of staff-resident physical abuse to the Director. [s. 24. (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 any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, or may occur, immediately reports that suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified

upon becoming aware of alleged, suspected or witnessed incident of abuse of a resident, which resulted in a physical injury to the resident, or caused distress to the resident that could potentially be detrimental to the resident.

Related to Intake #012781-17 for resident #022:

The Supervisor of Care (SOC-RN #103) submitted a Critical Incident Report (CIR) to the Director, on an identified date and time, related to an alleged incident of staff to resident physical abuse, involving resident #022. The alleged abuse was reported to the Director three days after the alleged abuse was reported by resident #022.

The CIR provided the following details, of the alleged abuse:

- Resident #022 indicated to the Registered Nurse (RN) #125, on an identified date and time, that had been physically abused by an unspecified individual. Resident #022 indicated to RN #125 that was afraid that the individual would return to their room and cause further harm. The CIR indicated that resident #022 had bruises on identified body parts.

During an interview, Registered Nurse (RN) #125, who was the Charge Nurse on duty on the identified date of the alleged abuse, indicated to Inspector #554, that resident #022 indicated that had been physically abused by an individual. The RN #125 indicated that resident had bruising on identified body parts. Resident #022 indicated to RN #125 that the bruises were from an individual physically abusing resident over a two week period. The RN #125 indicated that did not notify resident #022's family member of the abuse allegation and/or injuries. Registered Nurse #125 indicated that reported the allegation and injuries to the On-Call Manager, who was the SOC-RN #103. The RN #125 indicated that was not directed to notify the family member, of the allegation and or injuries. Registered Nurse #125 indicated being aware that a family member should have been notified.

The SOC-RN #103, who was currently the Interim Director of Care at the time of this inspection, indicated to Inspector #554 that was aware of the alleged abuse of resident #022, and resident's assessed injuries. The SOC-RN #103 indicated that RN #125 reported the alleged abuse and injuries to the SOC-RN #103. The Supervisor of Care-RN #103 indicated to Inspector #554, that had told RN #125 that notification to resident's family member, regarding the alleged abuse and injuries could wait until the following day. The SOC-RN #103 indicated at the time,

resident #022 was being treated for an infection and it was the SOC-RN's belief that resident #022 may have been confused as to what they were alleging, and the SOC-RN wanted to wait until the following day to investigate the allegation before notifying the family member.

The SOC-RN #103 indicated the family member for resident #022, was not notified of the alleged abuse and injuries until one day after the alleged abuse was reported by the resident. The Supervisor of Care-RN #103 indicated being aware that allegations of abuse resulting in physical injury was immediately reportable to resident's family member.

The Registered Nurse #125 and the Supervisor of Care-Registered Nurse #103 failed to ensure, that the family member of resident #022, was immediately notified of the alleged abuse and physical injury of resident #022. [s. 97. (1) (a)]

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 resident's Substitute Decision Maker (SDM) and any other person specified by the resident are immediately notified upon becoming aware of alleged, suspected or witnessed incident of abuse of a resident, which resulted in a physical injury to the resident, or caused distress to the resident that could potentially be detrimental to the resident, to be implemented voluntarily.

WN #7: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Intake #013116-17 for resident #023:

Resident #023's diagnoses included cognitive impairment and other identified health conditions.

Resident #023 had a physician's order for an identified medication to be given daily.

The clinical health record for resident #023, was reviewed by Inspector #554 for approximately a three month period, indicating that resident had abnormal laboratory values. On an identified date, the physician reviewed resident's abnormal bloodwork, and suggested to repeat bloodwork in one week; and to reassess the identified medication in a month. The clinical health record for resident #023 did not contain a physician's order to hold or discontinue the identified medication.

The Supervisors of Care-Registered Nurses (SOC-RN) #103 and #124, indicated that Registered Practical Nurse #109 and Registered Nurse #121 wrongly transcribed the physician's order. The SOC-RN #103 indicated that the reassessment of the identified medication, which was to have taken place one month following the physician's order on the identified date, did not occur. The SOC-RN #103 indicated that there had been no physician's order to HOLD or discontinue the medication between the identified six-week period.

Resident #023 suffered no ill effect, related to the identified medication not being administered.

The licensee failed to ensure that drugs were administered to resident #023 in accordance with the directions for use specified by the prescriber.

2. Medication Incidents were reviewed by Inspector #554, for a three month period. There were eleven medication incidents reported to have occurred during this period. Of the eleven medication incidents, four of the eleven incidents involved medications being wrongly administered to residents #014, #025, #026, and #027.

Medication Incident Report (MIR) identified the following:

- Resident #014 had a physician's order for a controlled substance to be administered twice a day (14 hours apart). The MIR indicated that on an identified date, a registered nursing staff administered one dose of the identified medication three hours after one dose had already been administered. The medication error was discovered one hour later. The physician was contacted, and orders received to monitor resident #014's vital signs. There was no indication in the clinical heath record that resident #014 sustained any ill effect as a result of this medication incident.

- Resident #025 had a physician's order for an anti-hyperglycemic medication to be administered at an identified time. The MIR indicated on an identified date, a registered nursing staff administered the wrong dose, and the medication error was discovered approximately two hours later. Resident #025's identified vital sign was taken, resident was monitored, and physician was notified. There was no indication in the clinical heath record that resident #025 sustained any ill effect as a result of this medication incident.

- Resident #026 had a physician's order for an identified medication to be applied daily. The MIR indicated that on an identified date, a registered nursing staff went to remove the identified medication, and found that resident #026 had two medications applied. The physician for resident #026 was notified, and orders were received to remove both patches and hold the identified medication for 24 hours, and to resume the medication the next day. There was no indication in the clinical heath record that resident #026 sustained any ill effect as a result of this medication incident.

- Resident #027 had a physician's order for a controlled substance to be administered at a specified time. The MIR indicated that on an identified date, a registered nursing staff administered the controlled substance at a specified time.

There was no order to administer the identified medication at that time. The Medication Incident Report identified that resident #027 was monitored by Registered Nurse #107. There was no indication in the clinical heath record that resident #027 sustained any ill effect as a result of this medication incident.

Registered Practical Nurse #109, Registered Nurse #107, and Supervisors of Care-Registered Nurses #103 and #124, all indicated to Inspector #554, that registered nursing staff were expected to administer drugs to residents, as directed by their attending physicians.

The Supervisors of Care-Registered Nurses #103 and #124 confirmed that residents #014, #025, #026, and #027 suffered no ill effects related to the above identified medication incidents, in which registered nursing staff did not administer drugs in accordance with directions by the prescriber.

The licensee failed to ensure that drugs were administered to resident #014, #025, #026, and #027 in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (554)

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, that corrective action is taken as necessary, and a written record is kept of everything required under O. Reg. 79/10, 135 (2), clause (a) and (b).

Medication Incidents were reviewed by Inspector #554, for a three month period. There were eleven medication incidents reported to have occurred during this period. Of the eleven medication incidents, four of the eleven incidents involved medications being wrongly administered to residents #014, #025, #026, and #027.

In addition, Inspector #554, reviewed a medication incident involving resident #023, which occurred on an identified date.

The Supervisor of Care-Registered Nurse (SOC-RN) #124, who was the Lead for Medication Management in the long-term care home indicated to Inspector #554, that SOC-RNs #103 #124 reviewed any medication incidents. The SOC-RN #124 indicated that recorded each medication incident into an electronic spread sheet for tracking purposes only. The SOC-RN #124 indicated that did not analyze the incidents for trends.

The Supervisors of Care-Registered Nurses #103 and #124, and the Accreditation-Compliance Lead indicated to Inspector #554, that the medication incidents were not analyzed. The SOC-RNs #103 and #124, and the Accreditation-Compliance Lead indicated that this was an identified gap in the Medication Management within the long-term care home, and such had been identified as an area of improvement.

Supervisor of Care-Registered Nurse #103, who was currently the Interim Director of Care at the time of this inspection, indicated that post medication incidents involving residents #014, #023, #025, #026, and #027 indicated that no corrective action was taken, by the licensee, to prevent a re-occurrence of the medication incident.

The interim Director of Care and the Accreditation-Compliance Lead indicated to Inspector #554, that there had been no corrective action taken specific to medication incidents occurring within the long-term care home.

The licensee failed to ensure that all medication incidents, and adverse drug reactions were reviewed and analyzed, and that corrective action was taken as necessary. [s. 135. (2)]

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 medication incidents and adverse drug reactions are documented, reviewed and analyzed, that corrective action is taken as necessary, and a written record is kept of everything required under O. Reg. 79/10, 135 (2), clause (a) and (b), to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaints concerning the care of a resident or the operations of the home are immediately forwarded to the Director.

Related to Intake #013116-17 related to resident #023:

A family member for resident #023, submitted a written complaint to the licensee, on an identified date.

The written complaint from the family member, voiced concerns related to medication management for resident #023, an identified medication incident involving the resident, lack of communication to the family member surrounding a change in resident's condition and/or medication profile, and refusal by the registered nursing staff, and Supervisor of Care-Registered Nurse (SOC-RN) #103 to provide the family member access to resident's clinical health record.

The licensee's investigation related to the written complaint was provided to Inspector #554. The investigation (by the licensee) provided documentation that the written complaint, was received by the licensee. The complaint letter was attached to a form titled "Client Complaint Form", which was stamped as received on an identified date.

The Administrative Assistant indicated to Inspector #554, that was responsible for forwarding all written complaints to the Director, and maintaining documentation of the same. The Administrative Assistant indicated being aware that a written complaint had been received from resident #023's family member. The Administrative Assistant indicated that the written complaint was not forwarded to the Director, but believed that the Director of Care may have submitted a Critical Incident Report related to the complaint and associated medication incident.

The Administrator indicated initially, to Inspector #554, that the written compliant from the resident #023's family member had been submitted to the Director, but later, that day, indicated that there had been an oversight in submitting the written complaint, and the complaint was never submitted to the Director.

The licensee failed to submit a written complaint from a family member, regarding the care of resident #023, and the operations of the home to the Director. [s. 22. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Device (PASD) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the criteria required under LTCH Act, 2007, c. 8, s. 33 (4) are satisfied, specifically to an assistance device.

On identified dates, Inspector #461observed resident #007's bed with an assistance device applied.

Review of resident #007's health records indicated that resident had cognitive impairment. Resident's current written plan of care did not include the identified PASD as part of the planned care for resident.

The RPN #109 indicated to Inspector #461, that a resident #007's family member requested the assistance device. The RPN #109 confirmed that resident was not referred to the Least Restraint Team and physiotherapist for assessment of the assistive device.

PSW #110 indicated to inspector #461 that resident #007 had been using the identified Personal Assistance Service Device (PASD) as requested by resident's family member.

The Supervisor of Care-Registered Nurse (SOC-RN) #107 (Lead of the Least Restraint Team) and the interim DOC, indicated to Inspector #461, that staff were expected to follow the home's policy "Personal Assistance Service Device" (effective date March 1, 2017) when implementing PASDs. The DOC indicated that if a registered nursing staff member assessed that a need for a PASD was identified for a resident, must send a referral to the Least Restrain Team and Physiotherapist for assessment, obtain a consent from the resident or SDM, obtain a physician's order, and update the plan of care. The PASD cannot be implemented until the physician's order had been obtained. The DOC and SOC-RN #107 confirmed that the staff did not follow the home's process when implementing PASD for resident #007.

The licensee failed to ensure that resident #007's identified assistive device was assessed as a PASD, approved by the physician, and included in the plan of care before implementing the intervention. [s. 33. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 120.
Responsibilities of pharmacy service provider
Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
2. Evaluation of therapeutic outcomes of drugs for residents.
3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
5. Educational support to the staff of the home in relation to drugs.
6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. The licensee failed to ensure that the pharmacy service provider participates in risk management and quality improvement activities, specifically a review of medication incidents.

Medication Incidents were reviewed by Inspector #554, for a three month period. There were eleven medication incidents reported to have occurred during this period. Of the eleven medication incidents, four of the eleven incidents involved medications being wrongly administered to residents #014, #025, #026 and #027.

The Medication Incidents reviewed, by Inspector #554, failed to identify that the medication incidents were reviewed by the contracted pharmacy service. Section III, and Section IV of the Medication Incident Reports identified that such sections were to be completed by Pharmacy Operations Manager, and or Pharmacy Consultant. Medication incidents for resident #014, #026, and #027 failed to identify that the pharmacy service provider was informed of the medication incident.

The Supervisor of Care-Registered Nurse (SOC-RN) #103, who was currently the Interim Director of Care at the time of this inspection, indicated to Inspector #554, that the pharmacy service provider, and or Pharmacy Consultant was only informed of Medication Incidents involving pharmacy errors, not medication incidents where registered nursing staff made the actual error.

The licensee failed to ensure that the pharmacy service provider participated in risk management and quality improvement activities, specifically a review of medication incidents relating to residents #014, #026 and #027. [s. 120. 3.]

Issued on this 28 day of June 2018 (A1)

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West, Suite #303
OSHAWA, ON, L1J-2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest, bureau 303
OSHAWA, ON, L1J-2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by CRISTINA MONTOYA (461) - (A1)

Inspection No. / No de l'inspection : 2018_523461_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 023197-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 28, 2018;(A1)

Licensee / Titulaire de permis : The Regional Municipality of York
17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1

LTC Home / Foyer de SLD : York Region Maple Health Centre
10424 Keele Street, Maple, ON, L6A-2L1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Dianne Turcotte

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

To The Regional Municipality of York, 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 :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee is hereby ordered to:

1. Immediately start covering the cost for equipment and supplies that ensure resident safety, such as fall protective devices.

2. Review residents #004, #007, #029, #030, #031, #033, #034, #035, #036, #037, and any other residents who are currently and/or have previously paid for the identified fall protective devices, to determine which residents paid for those items, the amount paid, and reimburse the residents or Substitute Decision Makers for those costs.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not charged for goods and services that the licensee is required to provide to residents under agreement between the licensee and a Local Health Integration Network, specifically, fall protective devices.

Under Long-Term Care-Service Accountability Agreement (L-SAA) Policy: Long-Term Care Homes (LTCH) Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment: The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, including but not limited to: c. Equipment and supplies to ensure resident safety
d. Equipment and supplies to prevent resident falls

On an identified date, during an interview with the Physiotherapist (PT), the PT indicated to Inspector #461, when identified fall protective devices were recommended for resident's safety and prevention of injuries from falls, the families had to purchase the devices. The PT indicated the licensee directed the PT that the identified fall protective devices were personal devices and therefore purchased by the resident or families. The PT indicated that had recommended the identified fall protective devices for resident #007, and the family was in the process of purchasing the safety items. The PT also indicated that resident #004 was using the identified safety devices, which were purchased by the resident's family. The PT indicated there were eight additional residents using the identified protective device that were paid for by the family. These included residents #029, #030, #031, #033, #034, #035, #036, and #037.

Review of the progress notes for resident #007, indicated that RPN #115 sent a referral to the Occupational Therapist (OT) and Physiotherapist (PT) requesting the identified fall protective devices for the resident. The PT measured the resident #007 for the identified fall protective devices, and provided the family with information where they can purchase the devices.

Review of the progress notes for resident #004, the PT indicated that resident #004 should wear the identified fall protective device to prevent falls with injuries.

The family members of residents #007 and #004, indicated that the home asked them to purchase the identified fall protective devices. Resident #007's family member indicated that had been given the measurements to purchase the identified fall protective devices. Resident #004's family member said that bought a set of protective devices for resident a long time ago when the nurse asked the family member to.

RPN #115 indicated to inspector #461 that when a resident needed the identified fall protective devices, the nursing staff and the PT had a discussion with the resident's family before implementing the interventions, as the family was required to purchase the mentioned protective devices.

The Administrator indicated that approximately seven years ago, the licensee decided to have families purchased the identified fall protective devices as they were considered personal devices and could not be reused on other residents. The families had been given a list of vendors outside the home; the home did not benefit financially from these purchases. The Administrator confirmed to Inspector #461 that the families of resident #004 and the other eight residents identified by the PT that were using the identified fall protective devices had to purchase the devices.

The licensee failed to ensure that the residents were not charged for goods and services that the licensee was required to provide to residents under an agreement between the licensee and a Local Health Integration Network, specifically, fall protective devices.
(461)

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

Jul 31, 2018(A1)

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28 day of June 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CRISTINA MONTOYA - (A1)

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

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Service Area Office / Bureau régional de services : Central East