Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2019	2019_777731_0023	003630-18, 005678-18, 006264-18, 006275-18, 008660-18, 025682-18, 027890-18, 004370-19, 006181-19, 006998-19, 008221-19	Critical Incident System

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

KRISTEN MURRAY (731), AYESHA SARATHY (741), HELENE DESABRAIS (615), TERRI DALY (115)

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): July 8 - 12, 2019

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of abuse and neglect:
Critical Incident Log #006181-19 / CIS #M605-000008-19
Critical Incident Log #005678-18 / CIS #M605-000011-18
Critical Incident Log #027890-18 / CIS #M605-000040-18
Critical Incident Log #003630-18 / CIS #M605-000008-18
Critical Incident Log #008660-18 / CIS #M605-000023-18

Related to improper care:
Critical Incident Log #006998-19 / CIS #M605-000014-19
Critical Incident Log #006275-18 / CIS #M605-000019-18
Critical Incident Log #025682-18 / CIS #M605-000038-18

Related to falls prevention:
Critical Incident Log #008221-19 / CIS #M605-000016-19
Critical Incident Log #004370-19 / CIS #M605-000005-19

Related to medication administration:
Critical Incident Log #006264-18 / CIS #M605-000018-18

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Housekeeping Aides, family members, and residents.

The inspectors also observed resident rooms and common areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed the home's investigation documentation and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning when assisting residents.

Critical Incident System (CIS) report M605-000038-18/Log #025682-18 was submitted to

the Ministry of Health and Long-Term Care (MOHLTC), related to an incident of improper/incompetent treatment of a resident that resulted in harm.

On a specific date, resident #002 was having a shower, when the staff member transferred the resident by themselves, and the resident sustained a fall.

A review of the clinical record and the care plan in place on the date of the incident showed that resident #002 required: Two + persons physical assist with the transfer to the tub and for the actual bathing process.

The critical incident report and homes investigative notes indicated that the staff member admitted that they had transferred resident #002 by themselves, however, were aware that the care plan stated two staff to provide physical assistance with transfers to the tub.

During interviews with Registered Nurse (RN) #112 and Personal Support Worker (PSW) #111, they both stated that at the time of the fall the care plan indicated that resident #002 required two staff for all transfer to the tub.

Director of Care (DOC) #101 acknowledged that the investigation concluded that the care plan for resident #002 was not followed and that the actions of the staff resulted in injury. They stated that it is the expectation of the home that the care plan would be followed and that staff use safe transferring techniques when assisting residents.

A review of the home's policy Positioning, Transferring and Lifting Policy and Procedures NPS 7.11, last revised January 1, 2018, stated in part:

"PURPOSE: This policy is to ensure that all those who provide direct healthcare to residents use safe transferring, positioning and lifting techniques to safeguard the resident, prevent pressure injuries, skin tears and contractures, and to protect staff's health and wellbeing.

1. Safety: Staff must use safe transferring, positioning and lifting devices or techniques when assisting residents.

3. Plans of Care: The resident's positioning, transfer and lift requirements and the number of staff required for transfers and lifts will be communicated to staff via the resident's plan of care.

6. Lifts: Two staff are required to transfer lift (ceiling lift, Hoyer lift sit-stand lift) a resident. This should be documented in the care plan.

-No staff member shall complete a two-person lift alone. Both staff members must remain present until the two-person lift is complete. If two staff members are not available, the mechanical lift and transfer of the resident will not be preformed." [s. 36.]

2. The home submitted Critical Incident System (CIS) report #M605-000014-19 to the Ministry of Health and Long-Term Care (MOHLTC) related to resident#006 sustaining an injury while being transferred and repositioned in their wheelchair by a staff member. The CIS report stated that Personal Support Worker (PSW) #120 transferred resident #006 from bed to wheelchair. PSW #120 then adjusted the head rest of the wheelchair, which resulted in laceration to the resident.

Multiple assessments for resident #006 indicated that they needed to have two persons assisting for transfers and that staff were to use a mechanical lift if they found the resident exhibiting specific symptoms. The resident's plan of care prior to the incident also indicated that the resident required physical assistance by two staff and that staff were to use the identified lift if the resident was exhibiting specific symptoms.

During an interview with PSW #120, they said that after getting resident #006 dressed, they transferred the resident from their bed to wheelchair using the lift and then positioned the wheelchair. PSW #120 said they noticed that the headrest on the wheelchair was swiveling so they adjusted it and when they adjusted the resident in the wheelchair the headrest hit the resident, causing a laceration. PSW #120 said that the proper way to transfer this resident according to their plan of care was for two people to use a mechanical lift and that the incident could possibly have been prevented had they waited for another staff member to assist them with the transfer.

In another interview, Registered Nurse #118 said that they responded to the incident and that PSW #120 did not follow the home's policy of having two staff members transfer resident #006. They stated that the resident's injury was caused by the improper transfer and that the incident could have been prevented if PSW #120 had followed the home's policy.

The Assistant Director of Care (ADOC) #110 said, when interviewed, that PSW #120 failed to follow the home's policy on having two staff for the transfer using a lift. They said that the home's internal investigation indicated that PSW #120 transferred resident #006

into their wheelchair alone and adjusted the headrest while the resident was in a specific position, which resulted in the laceration. The ADOC #110 explained that the resident should have been placed in an alternative position before adjusting the headrest on the wheelchair. ADOC #110 said that the resident's wheelchair had been assessed by Occupational Therapy and there was no defect in the wheelchair. They acknowledged that resident #006's injury was caused by the improper transfer.

The licensee failed to ensure that staff used safe transferring and positioning when assisting resident #002 and resident #006. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Critical Incident System (CIS) report #M605-000008-19/Log #006181-19 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to unknown injuries of resident #008, and potential staff to resident neglect.

A review of the home's policy #SkW2 "Skin and Wound Assessment and Intervention Policy and Procedures" dated December 1, 2017, stated in part "Interventions: A resident who exhibits altered skin integrity including breakdown, pressure injuries, skin tears, major bruising or wounds will: receive immediate treatment and interventions to relieve pain, promote healing and prevent infection as required."

In a review of the CIS report, progress notes in Point Click Care (PCC) and home's investigation, the following was noted:

On the morning of a specific date, a day Personal Support Worker (PSW) reported to a day Registered Practical Nurse (RPN) that resident #008 was found with an injury. The day RPN completed an assessment and resident #008 was transferred out to the hospital. The night shift RPN #114 and night shift PSW #113 that worked prior to the day shift were called in by Director of Care (DOC) #101 for interviews. RPN #114 was asked by DOC #101 if the resident had a fall and they said they didn't know. PSW #113 when asked if they saw the injuries, stated that they seemed like old injuries and not being aware if they reported them to the nurse. Later PSW #113 added that they had seen the injuries and reported it to the nurse. During their investigation resident #008 had told DOC #101 that they had rolled out of bed and injured themselves that night. Several days after, RPN #114 requested to speak to DOC #101 and told them that they had lied in the previous interview and that PSW #113 had told them about resident #008's injuries, had forgot about it and did not do an assessment and that no treatment was provided to the resident during the night shift.

During interviews with DOC #101, Assistant Director of Care (ADOC) #110 and RPN #108, all stated that when a resident is found with injuries by a PSW that they had to report it immediately to the nurse so that they could be assessed and treated. DOC #101

said that their expectation would have been that RPN #114 completed an assessment of the resident and provided treatment.

The licensee failed to ensure that when resident #008 was exhibiting altered skin integrity, skin tears or wounds, they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

Issued on this 23rd day of July, 2019

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

Original report signed by the inspector.