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
Oct 31, 2019	2019_763116_0002	015488-19, 016692-19, 016776-19	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

SARAN DANIEL-DODD (116), ASAL FOULADGAR (751)

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): October 2, 3, 4, 7, 8, 9, 10, 2019.

The following intakes were inspected:
Log# 015488-19 related to falls prevention
Log #'s 016692-19 and Log #016776-19 related to resident to resident physical abuse

Inspector #762 attended the inspection for shadowing purposes.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), registered nurses (RNs and RPNs), physiotherapist (PT), personal support workers (PSWs), residents and family members.
Note: non -compliance related to LTCHA, 2007, 79/10, s.19 and s.6(7) were identified during this inspection and has been issued under inspection report #2019_763116_0003, which was conducted concurrently with this inspection.

The inspectors reviewed residents' health records, staffing schedules, staff training records, internal investigation notes, conducted observations and reviewed and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Long-Term Care (MLTC) received a critical incident system (CIS) report related to an incident involving resident #006 that required transfer to an external health care provider. The resident returned to the home on an identified date with specified diagnoses. As per CIS report, resident #006 experienced an identified number of incidents between a specified period. Resident #006 has continued to sustain incidences of falls since they returned to the home over a three month period.

A review of resident #006's written plan of care under two specified sections indicated discrepancies related to the required mobility device and level of assistance required for the resident.

A review of progress notes for an identified date, indicated the resident should not use the identified mobility device due to safety concerns. A review of physiotherapy (PT) evaluation notes for an identified period, indicated that the resident was using a different mobility device. Further review of PT evaluation notes for a separate identified period, indicated that resident #006 requires a specified level of assistance which contravenes with the written plan of care.

An interview held with personal support worker (PSW) #111, indicated that resident #006 does not ambulate, and requires the use of the specified mobility device and specified level of assistance documented in the written plan of care.

An interview held with RPN #109, indicated that resident #106 currently uses the mobility device documented in the written plan of care. An interview with PT #112, confirmed that

resident #006 does not ambulate and requires the identified mobility device documented in the written plan of care as their assistive device.

During observations conducted by inspector #751 on multiple separate occasions, resident #006 was noted to be sitting in an identified mobility device which differs from the prescribed mobility device as per the written plan of care.

An interview held with ADOC #108, indicated resident #006 has been using a specified mobility device since their return to the home, and further indicated the written plan of care did not identify the prescribed assistive device to be used by resident #006. ADOC #108 confirmed that the resident's written plan of care does not provide clear direction to the staff and others who provide direct care to the resident related to resident's appropriate assistive device and the level of assistance for mobility and transfer. [s. 6. (1) (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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.