Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 9, 2020	2020_763116_0007	019829-19, 020760-19, 002418-20	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): February 7, 10, 11, 12, 13, 14, 2020.

During this inspection Critical Incident System (CIS) reports were inspected related to falls prevention, medication incidents and prevention of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Associate Director(s) of Care (ADOC), registered staff members (RNs & RPNs), personal support workers (PSWs), physiotherapist (PT), activation staff members and residents.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed the home's staffing schedule, the home's investigation notes, complaints and CIS binders, residents' clinical health records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report indicating resident #003 sustained an injury. A required assessment was initiated to monitor resident #003's status and the resident was transferred to the hospital for further assessment. The resident returned to the home on the same day and revisions were made to an identified medication.

A review of resident #003's clinical health record including the current written plan of care and a required assessment indicated the resident required a prescribed level of assistance to complete certain tasks.

An interview with personal support worker(PSW) #115 indicated resident #003 required a specified level of assistance for required tasks. PSW #115 indicated that on an identified date, when resident #003 sustained an injury, they provided care to resident #003 in a manner that contravened with the required level of assistance as indicated in the written plan of care.

In an interview with Director of Care (DOC) #110, the home's investigation process outcome as well as resident #003's written plan of care were reviewed and DOC #110 indicated that PSW #115 did not follow the resident's plan of care when they assisted resident #003 on the identified date.

The home failed to ensure that the care set out in resident #003's plan of care was provided to them in terms of the required level of assistance to complete certain tasks. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged or suspected incident of abuse of a resident by anyone that the licensee knows of was immediately investigated and appropriate action was taken in response to every such incident.

Ontario Regulation 79/10 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) indicating suspected resident to resident abuse had occurred between resident #002 and resident #004.

According to the CIS, resident #002 reported to PSW #107 that an individual came to their room and made inappropriate actions towards them.

Review of resident #002’s electronic progress note in PCC, documented the reported incident and that resident #002 was unaware of who the individual was.

Review of resident #004’s clinical record indicated there were no previous incidents of

the resident displaying inappropriate behaviour towards residents in the home.

Inspector #116 attempted to interview residents #002 and #004 however, they were unable to recall the assertions. During an interview with resident #002 they stated they currently felt safe and protected.

Separate interviews held with PSW #107, RPN #117 and RN #123, who were assigned to the unit on the date of the alleged incident verified the following:

In an interview with PSW #107, it was reported that resident #002 brought the concerns along with a description of resident #004 to the attention of PSW #107 on the date of the alleged incident. PSW #107 acknowledged the depiction resident #002 provided of resident #004. PSW #107 recognized that resident #002 has an identified medical diagnosis however, they reported the assertions to RPN #117 as the vocalized concerns of resident #002 were reasonable grounds to report the suspicion to the Director.

An interview held with RPN #117 indicated they were aware of the homes zero tolerance for abuse policy and what is constituted as abuse. During the interview, RPN #117 acknowledged they were made aware of the assertions made by resident #002 and suspicions that resident #004 was the alleged aggressor. RPN #117 further stated they withheld providing resident #004's name to RN #123 as they did not observe the incident and didn't want to get resident #004 into trouble. RPN #117 acknowledged they had not fully disclosed the assertions reported to them which delayed initiation of an immediate investigation and appropriate action to be put in place to protect resident #002 and other residents on the unit.

In an interview, RN #123 stated that the assertions of resident #002 reported by RPN #117 did not disclose that resident #004 was the alleged resident involved. RN #123 stated that if they were apprised, required assessments would have been immediately initiated for resident #004 and their name included in the after hours report made to the Ministry. [s. 23. (1) (a)]

2. In an interview, behavioural supports Ontario (BSO) RN #108 stated that the required assessment was initiated for resident #004 two days after the alleged incident, once becoming aware of the assertions of abuse towards resident #002.

There was no documentation in resident #004's progress notes that support an immediate investigation, required assessments or other interventions were put in place

for resident #004 during the evening of the alleged incident, up to and including one day after the assertions were made by resident #002.

Review of the homes internal investigation notes and an interview held with DOC #110 established that upon review of the homes surveillance camera footage, resident #004 was observed taking resident #002 into resident #002's room and noted entered and exiting at established time(s). RPN #117 was disciplined for matters which included failing to disclose the name of resident #004 to RN #123 related to the abuse allegation.

The DOC acknowledged that the immediate investigation did not include resident #004 and interventions should have been put in place for resident #004 upon report of allegations of abuse reported by resident #002.

The licensee has failed to ensure that every alleged or suspected incident of abuse of a resident by anyone that the licensee knows of was immediately investigated and appropriate action was taken in response to every such incident. [s. 23. (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, every alleged or suspected incident of abuse of a resident by anyone that the licensee know of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #3: 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 Registered Nurse (RN) #119 and Personal Support Worker (PSW) #120 used safe transferring and positioning device when assisting resident #005.

The sample was expanded to include resident #005 as an area of non compliance was identified related to resident #003's set plan of care was not followed as specified in the plan.

During the inspection, resident #005 was observed to be transferred from one area to another with the assistance of RN #119 and PSW #120, via a an identified device.

A review of resident #005’s clinical health record including the current written plan of care and a required assessment indicated the resident required a prescribed level of assistance and a specified device to complete certain tasks.

An interview with RN #119 indicated that the staff had been using different devices depending upon the location and/or position the resident was being transferred to/from. RN #119 acknowledged that the resident’s plan of care only indicated to use the prescribed device.

An interview with PSW #120 indicated that they had followed other staff members’ verbal directions in using the above-mentioned device while providing care to resident #005. During the interview with PSW #120, they were unable to view the resident’s written plan of care in the electronic system and acknowledged they had not reviewed resident #005’s written plan of care prior to providing care to the resident.

In an interview with Director of Care (DOC) #110, the above observations and interviews were reviewed. DOC #110 acknowledged that resident #005 required a specific device for detailed tasks according to the written plan of care and indicated that resident #005 was not assisted with safe transferring techniques on the specified date. [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 when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director with respect to the alleged or suspected incident of abuse of a resident by anyone included a description of the individuals involved in the incident, including, names of all residents involved in the incident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) indicating suspected resident to resident abuse had occurred between resident #002 and resident #004.

Review of the initial CIS report submitted to the Director and resident #002's progress note for a specified date, documented that the alleged resident was unknown.

Interviews held with PSW #107, RPN #117 and RN #123, who were assigned to the unit on the date of the alleged incident disclosed the following:

In an interview, PSW #107 expressed to Inspector #116 that resident #002 provided a description of resident #004. PSW #107 stated that their verbalized report to RPN #117 regarding the assertions made by resident #002 included the description and name of resident #004.

During an interview held with RPN #117, they acknowledged PSW #104 reported the suspicion that resident #004 was the alleged aggressor. RPN #117 further stated they did not fully disclose the description and resident #004's name to RN #123 as they did not observe the incident and didn't want to get resident #004 into trouble.

In an interview, RN #123 stated that the report communicated by RPN #117 did not include that resident #004 was the alleged resident involved. RN #123 further indicated that the omission resulted in resident #004's name not being included in the after hours report made to the Ministry and the initial CIS report.

The DOC acknowledged that the report to the Director excluded the description of all the individuals and the name of resident #004 involved in the incident.

The licensee has failed to ensure that the report to the Director included the description of the individuals and names of all residents involved in the incident. [s. 104. (1) 2.]

Issued on this 9th day of March, 2020

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

Original report signed by the inspector.