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
Apr 21, 2022	2022_892762_0007	017315-21, 001189-22	Complaint

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

MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 25, 28-31 onsite, and April 5 and 11, 2022, offsite

During this complaint inspection the following intakes were reviewed:
- Log related to multiple care items
- Log related to staffing and nutrition

During the course of the inspection, the inspector(s) spoke with IPAC lead, Physiotherapists (PT), Physiotherapist Assistants (PTA), Food Service Manager (FSM), Food Service Supervisors (FSS), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeeping Staff and Personal Support workers (PSWs)

During the course of this inspection the inspector observed infection prevention and control practices, monitoring of air temperature, resident and staff interactions, and conducted observation on resident home areas

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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 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 failed to ensure that there is clear directions to staff and others who provide direct care to resident #002 and #006, that sets out the use of the appropriate item

An anonymous complaint to the Director indicated resident #002 had an incident as a result of an intervention. PT #113's assessment documented in the progress notes, indicated that the intervention for the resident required to be different. As In the note, it was documented that a different intervention was being used on a different unit. PT #113 noted in their documentation the intervention being used on the different unit should be used now. A review of the resident care plan, which was in effect when the incidents occurred, and tasks dashboard did not contain this interventoin. In an interview, ADOC #107, indicated that the residents written plan of care did not contain the intervention. As a result of no clear direction, the resident was at risk for injury if the wrong intervention was used.

Sources: Progress notes; Care plan; Interview with ADOC #107 [s. 6. (1) (c)]

2. A review of resident #006's current care plan, and tasks dashboard did not contain a specific intervention. In separate interviews, ADOC #107 and PSW #110, indicated that the residents written plan of care did not contain the intervention the staff are to use for the resident. As a result of the no clear direction, the resident was at risk for injury if the wrong intervention was used.

Sources: Progress notes; Care plan; Interviews with ADOC #107 and PSW #110 [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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that the 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.

Multiple written complaints in an email format were forward to inspector #762, by SDM #111. These complaints were also sent to the Long-Term Care Home (LTCH). A review of the central intake server did not note these emails. A review of the Long-Term Care home's (LTCH), documentation provided by DOC #105 on indicated that the two emails were forwarded late and four emails were not forwarded. In an interview, DOC #105 indicated that the emails were either forwarded late or not forwarded to the director. As a result there was no risk to the resident.

Sources: Emails from SDM #118 and #111; Document from DOC #105; Interview with DOC #105 [s. 22. (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 the 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, to be implemented voluntarily.

Issued on this 21st day of April, 2022

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

Original report signed by the inspector.