Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 5, 2023
Inspection Number: 2022-1600-0001
Inspection Type: Complaint Critical Incident System
Licensee: The Regional Municipality of York
Long Term Care Home and City: York Region Maple Health Centre, Maple

Lead Inspector	**Inspector Digital Signature**
Najat Mahmoud (741773)	Najat Mahmoud Digitally signed by Najat Mahmoud Date: 2023.01.13 14:18:08 -05'00'

Additional Inspector(s)
Asal Fouladgar (751)
Ana Best (741722)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 5, 6, 8, 9, 12 to 14, 2022

The following intake(s) were inspected:

- 11 Critical Incident System (CIS) intakes related to falls prevention and management program.
- An intake related to a complaint of improper care of a resident.
- A CIS intake related to a failure/breakdown of the resident-staff communication and response system.
- Four CIS intakes related to alleged staff-resident abuse.
- Two CIS intakes related to medication management.
- Four CIS intakes related to responsive behaviour management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Prevention of Abuse and Neglect
Falls Prevention and Management
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) b, IPAC Standard section 9.1 (d)

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the Infection Prevention and Control program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, section 9.1 (d) of the IPAC Standards, states the licensee shall ensure that routine practices were followed in the IPAC program, including the proper use of Personal Protective Equipment (PPE).

Personal Support Worker (PSW) #101 was observed exiting a resident's room. PSW #101 then donned clean gloves in the hallway and proceeded towards another resident's room to provide resident care. PSW #101 confirmed that the expectation in the home is to don gloves at the point of care.

Failure to don gloves at the point of care increased the risk of transmission of infectious disease.

Sources: The home's policy, observations, and interview with PSW #101

[741773]

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) b, IPAC Standard section 9.1 (b)

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the Infection Prevention and Control program in accordance with the IPAC Standard. Specifically, section 9.1 (b) states the licensee shall ensure that hand hygiene is performed before and after contact with the residents' environment.

Contractor #112 was observed repairing equipment in a resident's room. Contractor #112 then exited the room and entered another resident room without performing hand hygiene.

The IPAC lead confirmed that it was the expectation of contractors visiting the Long Term Care Home (LTCH) to perform hand hygiene before contact with a resident's environment to minimize the transmission of infectious diseases.

Failure to perform hand hygiene before contact with the resident's environment increased the risk of transmission of infectious disease.

Sources: The home's policy, observations, and interview with the IPAC lead.

[741773]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident #002 was protected from sexual abuse by resident #001.

Section 2 of the Ontario Regulation 246/22 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".

Rationale and Summary

The home's Critical Incident Report (CIR) and the residents' clinical records indicated that resident #001 was observed conducting inappropriate sexual behaviour towards resident #002. Residents #001 and #002s' clinical records indicated that they had cognitive impairments, history of responsive behaviours including physical and verbal abuse towards each other, and that they were required to be closely monitored.

Activation staff #134 stated that when they observed resident #001 pass by resident #002, resident #001 exhibited an inappropriate sexual behaviour towards resident #002. Activation staff #134 further stated that resident #001's action startled resident #002 as they were sleeping in their assistive device during this incident.

Behavioural Support Ontario (BSO) RPN #135 confirmed that the two residents were being monitored closely due to previous history of physical aggression towards each other and that this incident was in a sexual context.

As a result of residents #001 and #002 being in close distance to each other considering their previous history of responsive behaviours and altercations, resident #001 had sexually abused resident #002.

Sources: The home's CIR and investigation notes, residents #001 and #002s' clinical records, interviews with activation staff #134, BSO RPN #135 and other staff.

[751]

WRITTEN NOTIFICATION: Reports of investigation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007, s. 23 (2)

The licensee failed to ensure that PSW #115 immediately reported suspected abuse of a resident.

Rationale and Summary

A CIR was submitted to the Director regarding an alleged abuse of a resident by PSW #133.
PSW #115 witnessed PSW #133 abusing the resident and confirmed that they did not immediately report this interaction until the end of their shift. PSW #133 continued to provide care to the resident for the remainder of the shift.

The home's investigation notes indicated PSW #133 was placed on an administrative leave the following day.

The DOC stated the home's expectation was for staff to report alleged abuse incidents immediately to the registered staff.

As a result of the inaction of the PSW to report the alleged abuse incident immediately, the resident was at increased risk of abuse as there were no interventions put in place to prevent further abuse.

Sources: The home's CIR, and investigation notes, resident clinical records, interviews with PSW #115, RPN #116 and DOC.

[741722]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 23 (2) of Act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg. 79/10, s. 104 (1) 3. v.

A) The licensee failed to include the outcome of all the staff members involved in an investigation submitted to the Director.

Rationale and Summary

A CIR was submitted to the Director related to an alleged staff to resident abuse. The licensee amended the CIR indicating that PSW #133 was placed on an administrative leave. No additional details were disclosed related to the outcome of the licensee's internal investigation.

The DOC disclosed that the outcome of the internal investigation did not substantiate the alleged abuse. They also acknowledged that the CIR was not updated with the outcome of the internal investigation.

Sources: The home's CIR and interview with DOC.

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B) The license failed to include the outcome of all the staff member involved in an investigation submitted to the Director.

Rationale and Summary

The home submitted a CIR to the Director related to alleged neglect of a resident by a staff member.

The CIR was amended indicating that the investigation continued.

Associate Director of Care (ADOC) #105 stated that the home completed their internal investigation, and the alleged neglect was not substantiated. ADOC #105 acknowledged that the CIR was not updated with the outcome of the home's investigation accordingly.

Sources: The home's CIR, and investigation notes, and interview with ADOC #105.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe positioning techniques when assisting a resident.

Rationale and Summary
A CIR was submitted to the Director related to improper care of a resident which resulted in harm.

The CIR indicated that PSW #100 was providing care to the resident by themselves when the resident rolled out of bed and fell to the ground, resulting in significant pain and transfer to hospital.

The resident's clinical records indicated that they required assistance of two staff for all aspects of care due to their impaired mobility.

The home's internal investigation notes indicated that PSW #100 repositioned the resident in their bed without the assistance of a second staff. The resident then rolled out of their bed and fell onto the floor.

RN #102 acknowledged that PSW #100 did not use safe positioning techniques since the resident required two staff.

Failure to utilize safe positioning techniques during care resulted in the resident's fall, significant pain, and a subsequent transfer to hospital.

Sources: The home's CIR, the home's internal investigation notes, resident's clinical records, and interview with RN #102.

[741773]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 23 (2) of Act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 112 (1) 3. v.

The licensee failed to report to the Director the outcome of the staff members involved in an investigation submitted to the Director.

Rationale and Summary

A CIR was submitted by the licensee to the Director related to improper care of a resident.
The CIR did not include the outcome of the staff member that was involved in the investigation.

The DOC stated that the home completed their internal investigation and acknowledged that the CIR was not amended accordingly.

Sources: The home's CIR, the home's internal investigation notes, and interview with DOC.

[741773]

WRITTEN NOTIFICATION: Medication Management System

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 8 (1) (b)

The licensee failed to include minimum two sources to obtain accurate and complete medication history during a resident's admission process.

O. Reg 79/10, s.114 (3) (a) requires written policies and protocols for accurate acquisition of all drugs in the medication management system to be implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Specifically, RPN #131 did not comply with the policy "Medication Admission" updated in August 2021 by Medisystem, which was included in the licensee's Medication Management Program.

Summary and Rationale

The resident's clinical records indicated that they were admitted to the home from community and that their family had brought in their medication vials on admission day. Further review of the resident's

clinical records indicated that two days after the admission date, they were transferred to hospital due to a significant change in their medical condition.

The home's investigation notes indicated that RPN #131 relied on only one source when they processed the resident's admission orders.

According to the home's "Medication Admission" policy, "the nurse must obtain an accurate and complete medication history by checking at minimum two sources of information".

RPN #131 stated that they did not refer to the secondary provided source in the resident's chart, as it was outdated and that they contacted the resident's community pharmacy but could not get a response prior to calling the physician to process the admission orders. Inspector #751 confirmed with RPN #131 that the date on the secondary source was approximately two weeks prior to the resident's admission date. RPN #131 and ADOC #105 were not able to clarify the reason behind considering the secondary source being outdated.

Registered Nurse (RN) #102 confirmed that the home's policy was not followed when RPN #131 relied on only one source when they processed the resident's admission orders.

Failure to obtain the best medication history of the resident based on the home's medication management policy, resulted in the resident not receiving their required medication which led to their hospitalization due to significant change in their health status.

Sources: The home's CIR, resident's clinical records, interviews with RPN #131, RN #102 and other staff.

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WRITTEN NOTIFICATION: Communication and Response System

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (c)

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

Rationale and Summary

Inspectors #741722 and #741773 observed that the call bell system on a specific resident home area (RHA) could be cancelled at the central nursing station and not at the point of activation.

The call bell system indicated through visual and audio display that a call bell was activated. The staff pocket phones also received an alert locating the point of activation.

Several call bells were activated, signaling a visual notification outside the residents' rooms. The call bells were then immediately deactivated without staff arriving to the point of activation. The visual notification outside the residents' rooms disappeared and the staff pocket phone received a "notification cancelled" message when the call bells were deactivated. Additionally, the pocket phone no longer indicated the location of where the call bell was activated.

ADOC #105, RPN #127 and PSW #128 indicated that calls could be cancelled from the central nursing station console.

The Administrator also confirmed that due to a malfunction, the call bell system in this specific RHA could be cancelled at a location other than the point of activation.

The Maintenance Supervisor #132 stated that the home was transitioning to an upgraded call bell system and acknowledged that call bells could be cancelled without being at the point of activation. It was further stated that resident care could be impacted due to cancelled call bells.

Failure to ensure that the call bells can only be cancelled at the point of activation, posed an increased risk to the residents' safety as staff were not alerted to respond to the residents' needs.

Sources: Observations, interviews with Maintenance Supervisor #132, Administrator and staff.

[741722]