Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Dec 12, 2018	2018_598570_0017	027350-18	Critical Incident System

Licensee/Titulaire de permis

Markhaven, Inc.
54 Parkway Avenue MARKHAM ON L3P 2G4

Long-Term Care Home/Foyer de soins de longue durée

Markhaven
54 Parkway Avenue MARKHAM ON L3P 2G4

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

SAMI JAROUR (570)

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): November 9, 13, 2018

Log #027350-18: Critical Incident Report (CIR) related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurse (RPN), Registered Nurse (RN), Physiotherapist (PT), Clinical Nurse Manager (CNM), Director of Care (DOC), and the Executive Director.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed the licensee's investigation notes and clinical health records for identified resident.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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 had failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

Related to Log # 027350-18

On identified date and time, the home submitted Critical Incident Report (CIR) to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that caused an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated staff reported an alteration to skin integrity to resident #001's specified body part. The Director of Care assessed the resident and noted the alteration to skin integrity. An identified assessment was completed and indicated an injury to a specified body part. The resident was sent to hospital for follow up. The CIR indicated the home completed an investigation into the circumstances leading to resident #001's injury and concluded staff had used an incorrect device to assist the resident, however, the cause of injury was not confirmed.

A review of resident #001's progress notes for identified period confirmed the resident had an alteration in skin integrity noted on a specified body part. Further assessments confirmed an injury that required the use of a specified intervention.

A review of resident #001's progress notes for a specified period , indicated the following:
-On a specified date, Physiotherapist Quarterly Reassessment indicated that staff used a specified device for transfer with assistance by two staff.
-On later specified dates, Physiotherapist Quarterly Reassessment completed and recommended a different device for transfer.

A review of resident #001's written plan of care in effect prior to the injury, directed the staff to use a specified device to assist the resident by two staff. This intervention was noted to have been created on an earlier date prior to the injury. The same plan of care directed staff to assist the resident by two staff physical assist with a different type of device to ensure safety.

A Review of the Documentation Survey reports of specified period for resident #001, indicated PSW staff had documented the use of a specified device to transfer resident #001 during different shifts on many occasions after the physiotherapist directed to use a different device to assist the resident on a specified date.

During an interview, PSW #100 stated that on a specified date and time, they called PSW #101 to assist resident #001 using a specified device. PSW #100 stated that, later that same day, PSW #103 assisted them to assist resident #001 using a different device. PSW #100 stated that they always used either device to assist the resident depending on what activity the resident needed to be assisted with.

During an interview, PSW #103 stated that on specified date, they assisted PSW #100 to with care for resident #001 using a specified device. PSW #103 stated that PSW staff sometimes used either device to assist resident #001.

During an interview, Physiotherapist (PT) #104 stated that resident #001 required the use of a different specified device from a specified date, and that registered nursing staff and the DOC were informed of the change. PT #104 further indicated that resident #001's plan of care should have been updated to reflect the use of one specified device to assist the resident.

During an interview, RPN #105 stated that the practice in the home is to follow the physiotherapist's recommendation of the use of specified devices to assist residents. A review of the written plan of care for resident #001 with RPN #105 confirmed that the written plan of care included the use of two different devices to assist the resident. The RPN indicated that staff should follow the physiotherapist's recommendation to use a specified device to assist the resident.

During an interview, RN #107 stated that the practice in the home is to go by the physiotherapist's assessment and recommendations regarding assisting residents with devices. The RN stated that the written plan of care should have been updated on a specified date following the physiotherapist's recommendations to include a specified device to assist the resident. The RN stated that if a resident is using a specified device, they cannot use a different specified device for safety. The RN indicated that the written plan of care did not provide clear directions to staff.

During an interview, Clinical Nurse Manager (CNM) stated that it is the responsibility of the physiotherapist to determine the level of assistance required for residents in the home. A review of the written plan of care for resident #001 with the CNM, the CNM confirmed that the written plan of care identified two different devices to assist the resident. The CNM indicated that the written plan of care should have been updated to use one specified device. The CNM confirmed that there was no clear directions to staff

regarding which device to use.

During an interview, the Executive Director (ED) acknowledged the plan of care for resident #001 had two different directions in regards to the use of two different devices. The ED confirmed that the written plan of care did not have clear directions in regards to which device to use to assist resident #001.

The licensee did not ensure that resident #001's written plan of care provided clear directions to staff and others who provided direct care to the resident specifically related to the use of devices to assist the resident. [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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.