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 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2017	2016_414110_0014	034422-16	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

DIANE BROWN (110)

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): December 20, 21, 22, 30, 29, 2016 and January 4, 2017

Critical incident log #033436-16 related to a resident injury with transfer to hospital along with complaint log #034422-16 related to plan of care not followed were inspected.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Physiotherapist, Registered staff, Occupational Therapist, Physiotherapist aide, Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **1 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	Legendé 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

This inspection was initiated related to a Critical Incident (CI), submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, whereby the home reported an incident that caused injury to resident #001 for which the resident was taken to the hospital. In addition, a complaint was received on an identified, related to the same identified resident and his/her plan of care not being followed at the time of incident.

Record review of the progress notes and staff interviews revealed resident #001 was known to staff to be at risk for falls and fell in the home sustaining an injury.

On an identified time, staff interviews along with additional findings, revealed that resident #001 fell. The inspection revealed PSW #142 observed resident #001 on the floor and was the first to approach the resident then RPN #144 arrived. While RPN #144 was completing an assessment while two additional PSWs #143 and #127 arrived. The inspection revealed that RPN #144 left the resident and PSW #127 repositioned the resident then PSW #142, #143 and #127 further moved the resident.

An interview with RPN #144 confirmed that he/she assessed resident #001 in one position when he/she left the resident to inform the Supervisor of Care and that when

he/she returned with the Supervisor of Care to further assess the resident, the resident had been repositioned. RPN #144 confirmed that he/she did not give direction to the PSWs to move the resident.

Interview with PSW #127 revealed they moved the resident in order to make him/her more comfortable however, he/she confirmed they were not provided direction to do so by the registered staff. PSW #127 stated that he/she realized later that he/she should not have moved the resident and should have waited for registered staff direction and had spoken to the Supervisor of Care around his/her concern.

Interview with the DOC confirmed that resident #001 should not have been moved by the PSWs without the direction of registered staff and that there was a lack of collaboration between the PSWs and registered staff in the assessment of the resident prior to moving resident #001 on the identified date and time of the fall. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

This inspection was initiated related to Critical Incident, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, whereby the home reported an incident that caused injury to resident #001 for which the resident was taken to hospital. In addition, a complaint was received on an identified, related to the same identified resident's plan of care not being followed at the time of incident.

Record review of the progress notes and staff interviews revealed resident #001 was known to staff to be at risk for falls and fell in the home sustaining an injury.

Record review of resident's kardex and written plan of care identified falls prevention and management interventions which included staff to remind the resident to use an identified device. This intervention was identified in resident's written plan of care on an identified date prior to the CI incident.

Interviews with PSW #143 and #127 revealed an awareness that resident #001 was at high risk for falls and required a mobility device, along with other interventions to keep the resident safe from falling.

Interview with Physiotherapist (PT) confirmed that he/she was involved and had been referred to assess the resident after the resident fell on an identified date, and that the

resident was at falls risk. The PT recommended a mobility device to be used at all times.

Interview with RN #146 identified that the PT assessed the resident for a mobility device. The RN stated the resident would abandon the device after using it for 5-10 minutes and that staff would go the get the device if he/she was without it.

Staff interviews with PSWs #142, #143 and #127 and further inspection revealed that on an identified date and time resident #001 had an unwitnessed fall, in an identified area of the home, without his/her mobility device in the vicinity. Resident was transferred to the hospital and later identified with a subsequent injury.

Inspection revealed that at an identified time resident #001 was observed walking with his/her mobility device in an identified hallway and entered a resident's room. Minutes later the resident was seen exiting the room without his/her mobility aide and walking towards the nursing station. Minutes later the resident stopped in the hallway and PSW #125 exited a resident room, headed into another resident room, while resident #001 follows staff #125. Staff #125 and resident #001 using his/her mobility aide exited the room and returned into the hallway.

The inspection revealed that at an identified time, a few minutes later resident entered a resident's room again and minutes later exited the room without his/her mobility device. PSW #125 walked down the identified hallway and past resident #001 who was now without his/her mobility device. PSW #126 while walking to the staff room turned and viewed the hallway with resident #001 present. PSW #126 exited the staff room and walked past resident #001 in the hallway still without his/her mobility device. The inspection revealed that resident #001 continued to walk without his/her mobility device down the identified hallway around the end loop and down the northeast hallway until he/she fell.

Record review of the staff schedule and assignments identified PSW #125 as resident #001's primary care staff for the afternoon shift on an identified day of the fall.

Interview with PSW #125 confirmed awareness of resident's need to use a mobility device related to his/her previous fall history in the home. PSW #125 identified that the resident was a little forgetful and sometimes he/she would have his/her mobility aide and sometimes not. PSW #125 confirmed he/she worked the afternoon shift of the identified date but did not recall redirecting the resident to get his/her mobility aide and recalled

only cuing the resident to slow down.

Interview with the DOC, confirmed the resident's plan of care was not followed as staff did not remind resident to use his/her mobility device. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2016_414110_0014
Log No. / Registre no:	034422-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 24, 2017
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	YORK REGION MAPLE HEALTH CENTRE 10424 Keele Street, Maple, ON, L6A-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dianne Turcotte

To The Regional Municipality of York, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

1. Within one week of receipt of this order, identify all residents in the home at risk of falls.
2. Review each of the resident's plan of care as identified in task 1 with direct care staff to ensure that the fall prevention interventions are provided to the residents as specified in the plan.
3. Develop and implement a quality improvement process to ensure that all residents assessed at risk of falls receive the fall prevention intervention(s) as specified in the plan of care.
4. Document all required steps 1-3 noted above.

The licensee shall prepare and submit a plan that includes tasks 1-3 and the person(s) responsible for completing the tasks. The plan is to be submitted to Diane.Brown@ontario.ca by March 15, 2017, and implemented by April 30, 2017.

Grounds / Motifs :

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

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Interview with the DOC, confirmed the resident's plan of care was not followed as staff did not remind resident to use his/her mobility device. [s. 6. (7)]

The severity of the non compliance is actual harm. The scope is isolated to resident #001 and the home has a history of non compliance in this area during inspection #2014_108110_0017 of December 18, 2014. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Toronto Service Area Office