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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
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419 rue King Ouest bureau 303
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 12, 2019	2019_684604_0003	000659-19	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

SHIHANA RUMZI (604)

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): February 7, 8, 11, 12, and 13, 2019.

Complaint log #000659-19, and Critical Incident System (CS) report log #000411-19, related to an injury of unknown cause was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and Substitute Decision Maker.

During the course of the inspection, the inspector conducted a review of the home's surveillance video footage, observations of staff to resident interactions, provisions of care, conducted reviews of health records, staff training records, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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 :

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

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint. The complainant indicated that resident #001 was transferred to hospital and had an injury of unknown cause. The complainant stated that resident #001 was to have identified intervention as indicated as the resident was unable to ambulate on their own.

On an identified date, the home had submitted Critical Incident System (CIS) report, to the MOHLTC. The CIS report indicated resident #001 was transferred to hospital for further assessment and once in hospital the resident had an identified diagnosis.

An interview was conducted on an identified date with the complainant who expressed concerns related to an injury of unknown cause to resident #001. The complainant indicated the home had investigated and no specified cause of the injury had been determined.

A review of resident #001's written plan of care was carried out and a focus related to identified responsive behaviours, and intervention included an identified interventions by staff.

Interviews were conducted with Personal Support Worker (PSW) #101 and #102. The PSW staff stated that resident #001 has always had an identified care on all shifts as the resident presented with responsive behaviours and had identified risks.

A review of resident #001's Point Click Care (PCC) documentation was carried out for an identified period. The documentation indicated the resident continued with an identified intervention on all shifts, assessment of resident's responsive behaviours were assessed and reviewed by Behaviour Support Services Ontario (BSO), and no incidents noted.

Inspector #604 carried out observations of the home's video surveillance footage with the Director of Care (DOC) #100 for an identified period. The DOC verified resident #001's room number and staff observed in the home's video surveillance footage.

As per PCC notes an injury was noted to resident #001's on an identified date and location by PSW #106 and was reported to RPN #118.

An interview was conducted with PSW #109, who indicated they worked on an identified date and shift in an identified location of the home and provided care to resident #001.

The PSW stated that it was the home's expectation that the identified intervention be provided to the resident as in accordance with their plan. The PSW was informed of Inspector #604's camera footage observation as indicated above and the PSW acknowledged that they did not provide the identified care as required.

An interview was conducted with PSW #115, who indicated they worked on an identified date and shift in an identified location of the home and provided care to resident #001.The PSW was informed of Inspector #604's observation of the camera footage for an identified date and shift as indicated above and the review of the written plan of care related to care. The PSW acknowledged that they did not provide care as required to resident #001.

An interview was conducted with PSW #114 who indicated they worked on an identified date and shift in an identified location of the home and provided care to resident #001. The PSW stated they were aware of the identified intervention. The PSW stated on an identified shift PSW #111 was assigned to provide care to resident #001 and they had observed PSW #111 not provide the identified care to the resident.

An interview was carried out with RN #116 who stated they worked on an identified date, time, and location of the home. The RN stated it was the home's expectation that staff provide care to the resident as specified by the plan of care. The RN stated that PSW #111 had been assigned to resident #001 on the identified date and acknowledged that PSW #111 did not provide the required care to the resident as specified throughout their shift.

An interview was carried out with PSW #111 who stated they worked on an identified date and shift in an identified location of the home. The PSW stated they were aware the care required for resident #001. The PSW was informed of Inspector #604's observation of the camera footage as indicated above and was informed of the times and durations resident #001 had not been provided the identified intervention. The PSW acknowledged that they did not provide care as required.

Interviews were carried out with RN #103 and RPN #104, and indicated they carried out a split shift on an identified date and shift. The RN and RPN stated that they were not informed of any concerns related to resident #001 and the resident had received the identified intervention as indicated on the identified shift.

An interview was carried out with PSW #106, who confirmed they worked on an identified

date and shift. The PSW stated when they arrived resident #001 was asleep in bed and appeared to be restless which indicated the resident required personal care. PSW #106, indicated they started to provide personal care to the resident and the resident started to complain of pain. The PSW stated they then reported the observation of the change on an identified location the nurse.

An interview was carried out with the home's DOC who stated resident #001 had been diagnosed with an identified injury of unknown cause, and initiated and investigation. The DOC stated through reviewing the home's video footage PSW #111 was placed on administrative leave. The DOC and Inspector #604 reviewed the home's video footage as indicated above and the DOC acknowledged that the staff did not provide the care as specified in the plan as identified monitoring was not consistently provided which left resident #001 without constant monitoring.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 23rd day of April, 2019

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

Ministère 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) :	SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2019_684604_0003
Log No. / No de registre :	000659-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 12, 2019
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 :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Upon receipt of this order the licensee shall prepare, submit, and implement a plan to ensure:
1. Care is provided to resident #001 as specified in the plan of care, as it relates to a specified intervention and all areas of Activities of Daily Living (ADL).

2. The home shall provide education to all front line staff on the home's expectation related to a specified intervention.

3. Staff attendance records of the education provided shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca, referencing report #2019_684604_0003, to Shihana Rumzi, LTC Homes Inspector, MOHLTC April 30, 2019.

Grounds / Motifs :

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

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint. The complainant indicated that resident #001 was transferred to hospital and had an injury of unknown cause. The complainant stated that resident #001 was to have identified intervention as indicated as the resident was unable to ambulate on their own.

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The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one of three residents. The home had a level 4 compliance history as the home had one or more related non-compliances related to LTCHA, 2007, c. 8, s. 6. (7), which is as follows:
-Voluntary Plan of Correction (VPC) issued on September 27, 2018, within report #2018_718604_0006
-VPC issued on February 9, 2018, within report #2018_523461_0002
-Compliance Order (CO) issued on February 24, 2017, within report #2016_414110_0014
- VPC issued on February 22, 2017, with in report # 2016_414110_0012 (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

Service Area Office /
Bureau régional de services : Central East Service Area Office