



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 le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jul 12, 20, 21, 25, 2011; 2011_083178_0002; Complaint

Licensee/Titulaire de permis

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Registered staff, personal support workers, Physiotherapist, Physiotherapy assistant, family member of resident.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home policies.

The following Inspection Protocols were used in part or in whole during this inspection:

Hospitalization and Death

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Definitions, Définitions. Lists abbreviations for WN, VPC, DR, CO, WAO in both English and French.



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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 subsections:**

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;**
- (b) the goals the care is intended to achieve; and**
- (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- (a) a goal in the plan is met;**
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or**
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits sayants :

1. Written plan of care for an identified resident did not provide staff with clear direction regarding care of that resident. [s.6(1)(c)]
2. Care was not provided to an identified resident as set out in the resident's plan of care. [s.6(7)]
3. An identified resident's written plan of care was not revised after the resident's condition and care needs changed. [s.6(10)(b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



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Specifically failed to comply with the following subsections:

- s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
 2. A description of the individuals involved in the incident, including,
 - i. names of any residents involved in the incident,
 - ii. names of any staff members or other persons who were present at or discovered the incident, and
 - iii. names of staff members who responded or are responding to the incident.
 3. Actions taken in response to the incident, including,
 - i. what care was given or action taken as a result of the incident, and by whom,
 - ii. whether a physician or registered nurse in the extended class was contacted,
 - iii. what other authorities were contacted about the incident, if any,
 - iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
 - v. the outcome or current status of the individual or individuals who were involved in the incident.
 4. Analysis and follow-up action, including,
 - i. the immediate actions that have been taken to prevent recurrence, and
 - ii. the long-term actions planned to correct the situation and prevent recurrence.
 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).
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Findings/Faits sayants :

1. The home failed to make a written report of the unexpected death of an identified resident to the Director. [r.107(4)]
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WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits sayants :

1. The home failed to ensure that staff used safe transferring techniques when assisting an identified resident.

The home's policy for mechanical lifts (policy # NU-0603-01) does not include a policy for use of the standing lift.

Director of Nursing was unable to provide the inspector with the dates that home staff received training on the standing lift or the names of staff who attended the training, stating that the home "has no record except that staff say they had the training".

2. Plan of care for an identified resident states the resident is to be transferred using the standing lift and two persons for constant supervision. An identified staff member confirmed that she did not transfer the resident as directed in the resident's plan of care. [r.36]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records



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Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits sayants :

1. Home's policy for mechanical lifts (policy # NU-0603-01) does not include a policy for the use of the standing lift. LTCHA,2007-O.Reg.79/10, s. 30(1)1 requires that for each of the organized programs required under sections 8 to 16 of the Act, which includes Nursing and personal support services, there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.
[r.8(1)(a)(b)]

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's policy for mechanical lifts includes a policy for the use of the standing lift, to be implemented voluntarily.

Issued on this 9th day of August, 2011

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

Susan Liu # 178