Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Jul 22, 2021	2021_718535_0010	007214-21, 009730-21	Critical Incident System

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

VERON ASH (535)

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): June 29, 30, July 5, 2021.

The following intakes were completed during this inspection:

Log #009730-21- was related to falls, and
Log #007214-21- was related to abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care/Infection Prevention and Control (ADOC/IPAC) Lead, Direct of Environmental Services, Mechanical Team Lead, Administrative Assistant, registered staff (RN/RPN), personal support workers (PSW) and entrance screener (ES).

During the course of the inspection, the inspector conducted observations at the entrance of the home, resident home areas and staff to resident interactions, reviewed clinical health records, staffing schedule, internal investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity.

A critical incident report was received by the Ministry of Long-Term Care (MLTC).

A PSW reported that they observed a second PSW providing inappropriate personal care to the resident. The second PSW denied that the incident occurred. They further stated that another staff had trained them to use a specific method to perform the care; however that method was also unacceptable.

The Inspector asked about the resident's dignity and respect while performing care using the method specified. And the PSW's response indicated a lacking insight related to performing personal care and respecting the resident's dignity. They also stated that sometimes poor habits could be formed without conscious knowledge.

Source: CIS report, home’s investigation notes, interviews with PSWs and others. [s. 3. (1) 1.]

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 resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

A review of the home's Indoor Temperature and Humidity Logs indicated that resident room air temperature was not being measured and documented.

The home's Mechanical Team Lead verified that the air temperature was measured and documented in the common areas of the home; however they did not measure and document in writing the air temperature in two resident bedrooms in different parts of the home, as required by the Regulation.

Sources : Indoor Temperature and Humidity Logs, interview with Mechanical Team Lead and others. [s. 21. (2) 1.]

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 temperature is measured and documented in writing in at least two resident bedrooms in different parts of the home, to be implemented voluntarily.

Issued on this 23rd day of July, 2021

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

Original report signed by the inspector.