Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Original Public Report

Report Issue Date: July 21, 2023	
Inspection Number: 2023-1600-0002	
Inspection Type: Critical Incident System	
Licensee: The Regional Municipality of York	
Long Term Care Home and City: York Region Maple Health Centre, Maple	
Lead Inspector Deborah Nazareth (741745)	**Inspector Digital Signature** Deborah A Nazareth Digitally signed by Deborah A Nazareth Date: 2023.08.10 11:27:14 -04'00'
Additional Inspector(s) Sheri Williams (741748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4, 6-7, 10-12, 2023

The following intakes were completed in this Critical Incident (CI) inspection:

- Two intakes were related to improper care of a resident.
- Two intakes were related to staff to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of Assessments, Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure that staff collaborated with each other in the assessment of a resident so that their assessments were integrated, and were consistent with and complemented each other.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a resident being transferred to the hospital for a medical condition.

The resident's plan of care directs staff to observe them and to notify the doctor if their laboratory results are not within therapeutic range. The home's investigative notes indicated that a Registered Practical Nurse (RPN) emailed laboratory results for the resident to the doctor and copied in five nursing staff. There was no record of the doctor and nurses reading the laboratory results and no evidence of an assessment of the resident.

Progress notes for the resident noted a medical condition and indicated the nurse left a note in the doctor's book but did not contact the doctor. Two days later the resident had further medical concerns, and during their visit the doctor discovered the laboratory results were abnormal and sent the resident to the hospital.

The Assistant Director of Care (ADOC) stated the home's expectation was when laboratory results were outside of normal range, the nursing staff was to inform the doctor immediately, rather than email them. The Director of Care (DOC) stated the nursing staff are expected to read their email and for abnormal laboratory results to assess the resident and call the doctor. The DOC also indicated when the resident had medical concerns, the nursing staff should have called the doctor immediately.

Failing to ensure that staff collaborated in the assessment of laboratory results and care of the resident resulted in the resident having a medical condition and requiring hospitalization.

Sources: CIR, resident's clinical health record, home's internal investigative notes, Interviews with RPN, ADOC and DOC.
[741748]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

1. The licensee failed to ensure that staff complied with the home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

The Long-Term Care Home (LTCH) called the Ministry of Long-Term Care (MLTC) after hours line to report an incident of alleged abuse of a resident by a Personal Support Worker (PSW). The CIR indicated the alleged incident of abuse occurred during morning care and it was reported the same day by the resident to a PSW in the morning. The PSW did not report the incident immediately to their supervisor. The incident was not reported to a supervisor until the end of the shift, in the afternoon by another staff.

The LTCH's policy on Zero Tolerance of Abuse and Neglect stated all staff are required to immediately report to the appropriate supervisor in the home at the time of a witnessed or alleged incident of abuse or neglect.

The PSW acknowledged that the resident reported the alleged abuse to them and they did not report it to their supervisor. A Registered Nurse (RN) and the ADOC confirmed that the PSW should have reported the incident immediately.

As a result of the PSW not reporting the allegation of abuse to their supervisor immediately, the LTCH's investigation was delayed placing the resident at risk for further incidents.

Sources: Resident's progress notes and clinical record. LTCH's investigation notes. CIR. The LTCH's policy, Zero Tolerance of Abuse and Neglect Program Part B: Procedure. Interviews with PSW, RN and ADOC. [741745]

2. The licensee failed to ensure that staff complied with the home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

The LTCH called the MLTC after hours line to report an incident of alleged abuse of a resident by a PSW. The CIR indicated that when the PSW was assisting the resident into the recreation room, the resident

hurt themselves on the door frame. The resident stated they were hurt. A visitor who was present at the time of the incident reported that the PSW did not acknowledge or assess the resident's concern.

The LTCH's policy on Zero Tolerance of Abuse and Neglect stated all staff are required to immediately report to the appropriate supervisor in the home at the time of a witnessed or alleged incident of abuse or neglect.

The PSW confirmed that the resident stated they were hurt when coming into the recreation room, and they did not report this immediately to their supervisor. An RPN and the ADOC confirmed the PSW should have reported the alleged incident immediately.

When the PSW did not report the incident of alleged abuse to their supervisor immediately, appropriate actions and assessments were not completed until the next day which placed the resident at risk.

Sources: Resident's progress notes and clinical record. LTCH's investigation notes. CIR. The LTCH's policy, Zero Tolerance of Abuse and Neglect Program Part B: Procedure, last reviewed June 2019. Interviews with PSW, RPN, and ADOC.
[741745]