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

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Original Public Report

Report Issue Date: September 25, 2024
Inspection Number: 2024-1600-0002
Inspection Type: Proactive Compliance Inspection
Licensee: The Regional Municipality of York
Long Term Care Home and City: York Region Maple Health Centre, Maple

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12-13, and 16-18, 2024.

The following intake(s) were inspected:

- An intake related to Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Pain Management

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) (b)
Plan of care
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,
(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.

The licensee has failed to ensure that the staff and others involved in the different aspect of care of resident #001 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary

During this Proactive Compliance Inspection (PCI), Personal Support Worker (PSW) #110 stated that they transferred and assisted resident #001 for the task of an activity of daily living (ADL) on their own. PSW #110 stated the resident had been stable on their feet for transferring with assistance of one staff and they would ask for additional staff's assistance if the resident was not stable.

The resident's written care plan in Point Click Care (PCC) indicated they required assistance of two staff for that specific ADL. The care plan also indicated the

resident required assistance of one to two staff for transferring. Review of the last couple of physiotherapist quarterly assessment notes indicated the resident required assistance of two staff for transfers and use of mechanical lift based on the resident's overall condition.

Registered Practical Nurse (RPN) #113 acknowledged the resident's care plan was not reflecting the physiotherapist's assessment for the task of transferring and stated they would inform the physiotherapist for further assessment as they believed the resident's mobility had been improved. Multiple documentations in Point of Care (POC) by PSW staff indicated they had been transferring the resident or assist with bathing the resident with presence of one staff.

The home's Physiotherapist (PT) stated the resident required assistance of two staff for all transfers for their safety as the resident's physical mobility had been unstable and could suddenly change. The PT indicated nursing staff had not informed them otherwise and they would reassess the resident's mobility and transfer ability in this case with the presence of PSWs and registered staff to ensure their assessments were integrated and consistent.

There was a risk of harm to the resident when the nursing staff and the PT did not collaborate in assessing the resident's current ability for transfers.

Sources: Resident #001's clinical records, interviews with staff.