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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: January 9, 2025
Inspection Number: 2025-1600-0001
Inspection Type: Complaint Critical Incident
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): January 6, 7, 8, 9, 2025

The following intake(s) were inspected:

- An intake was related to resident care and supportive services
- An intake was related to staffing, care, recreation, and family council.
- An intake was related to neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

The plan of care, specifically the Medication Administration Record (MAR) , had been signed to indicate that the resident had their treatment applied, and they were not applied during an observation.

Sources: Complaint intake, observations, resident's physician's orders and plan of care, interview with PSW.

WRITTEN NOTIFICATION: Powers of Family Council

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee failed to ensure that when Family Council advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.
The Family Council minutes on a certain date, listed several concerns, however; there was no evidence of responses in writing. The Associate Administrator and the

Administrative Assistant both indicated that there was not a formal process in responding in writing to the Family Council.

Sources: Complaint intake, Family Council meeting minutes, and interviews with Associate Administrator and the Administrative Assistant.

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to resident in accordance with the directions for use specified by the prescriber.

The resident had been prescribed treatment to be applied as they were being monitored for a certain health condition and currently had symptoms, and they were not applied during an observation.

Sources: Complaint intake, observations, resident's physician's orders and plan of care, interview with PSW.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) The IPAC Lead will ensure all staff in a specific home area including agency staff are trained in the correct use of PPE donning and doffing. The IPAC Lead is to initiate and complete PPE policy review outlining the requirements for proper coverage of face while wearing the mask. Please keep the documentation of the training record.

2) The IPAC lead, or management designate will post signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring and the steps that must be taken if an infectious disease is suspected or confirmed in any individual. Keep a documented record of the where these posted signs are located throughout the home.

3. All records will be retained and made available to Inspectors immediately upon request.

Grounds
1)The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 11.6.

The Inspector observed staff in the outbreak unit, specifically a Personal Support Worker (PSW), was not wearing a mask while serving food inside the dining room. At

the time of the observation, the dining room was surrounded by the residents.

Improper PPE use and handling practices observed during these inspections pose a risk of infection to residents.

Sources: Observation, Interview with PSW.

2)The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 f).

The signs posted at the home's front entrance were intended to provide general information about individuals experiencing illness. However, these signs did not include information about COVID-19 or other infectious diseases, such as their signs and symptoms, the need for self-monitoring, or the steps to take if an infectious disease is suspected or confirmed in an individual. There were also no signs posted throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as the steps to that must be taken if an infectious disease is suspected of confirmed in any individual.

Residents may have been at an increased risk for infectious disease when signs were not posted to throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Sources: Observation, Interview with IPAC Nurse.

This order must be complied with by March 7, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.