Ontario

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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Mar 26, 2019	2019_684604_0004	028477-17	Complaint

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 Newmarket Health Centre
194 Eagle Street NEWMARKET ON L3Y 1J6

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

SHIHANA RUMZI (604), LAURIE MORRISON (747)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 26, 27, 28, and March 1, 2019.

An intake related to care not provided was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviews of health records, staff training records, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified date. The complainant stated that on an identified date the Long Term Care home (LTCH) informed the complainant that resident #002 sustained a fall. The complainant indicated that at the time of the fall Registered Practical Nurse (RPN) #102 confirmed the resident's identified device was turned off and was not functioning. The complainant stated that the resident had an identified device due to an identified diagnosis and was at risk for falls.

An interview was conducted on an identified date, with complainant #100, who stated that on an identified date RPN #102 called them and indicated that resident #002 had sustained a fall. The RPN had stated that they heard resident #002 calling out for help and the resident had fallen in an identified location of the home. During the conversation the complainant had asked the RPN to ensure that the resident's identified devices was turned on. The RPN informed the complainant that the identified device was found to be turned off. The complainant stated that they spoke to the previous Director of Care (DOC) who is no longer in the home related to the identified device being turned off and the DOC at that time had indicated that they would educate the staff on the identified device.

A review of resident #002's written plan of care and the Kardex was carried out and an identified focus directed staff to ensure that an identified devices was provided to the resident when they were utilizing an identified mobility device to prevent the resident from falling.

Observations were conducted for resident #002 on identified dates and times and during the observations the resident was observed to be utilizing an identified ambulation device without an identified device for fall prevention.

Interviews were conducted with Personal Support Worker (PSW) #105 and #112 who indicated they worked on an identified unit and provided care to resident #002. The PSW staff stated the resident was at risk for falls and the PSW's reviewed the above documentation and acknowledged that they had not seen an identified device to be on the resident's identified ambulation device as indicated on the plan of care and the plan of care was not followed.

An interview was conducted with the home's DOC #101, and was informed of the above observations, plan of care, and kardex was reviewed. The DOC and Inspector #604

conducted an observation for resident #002 and it was observed that the resident did not have an identified fall prevention device on their identified ambulation device which was acknowledged by the DOC and stated that the plan of care was not followed.

Issued on this 28th day of March, 2019

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

Original report signed by the inspector.