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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2017	2017_671684_0007	032409-16, 013647-17, 015714-17, 015720-17, 015721-17, 016389-17, 018285-17, 018415-17, 019641-17, 020797-17, 023202-17, 024099-17, 024245-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

SHELLEY MURPHY (684), SYLVIE BYRNES (627)

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): October 23-27, 2017.

This Critical Incident System Inspection was conducted as a result of the following 13 critical incident (CI) reports, the home submitted, in which

-Six CI reports alleged Staff to Resident Abuse

-Three CI reports alleged Resident to Resident Physical Abuse:

-Two CI reports were related to an Unexpected Death:

-One CI report for a Fall Causing Fracture

-One CI report for a Missing Resident:

A Complaint inspection #2017_671684_0006, was conducted concurrently with this Critical Incident System inspection.

The Inspector(s) conducted a tour of the resident care areas, reviewed resident's health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personal records, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident to staff interactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), families and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 VPC(s)
1 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	Legendé 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance for abuse and neglect of residents and that it was complied with.

A Critical Incident (CI) report was submitted to the Director during a specific month in 2017, alleging staff to resident neglect. The CI report alleged that PSW #127 had not provided basic care to resident #011.

Inspector #627 reviewed the home’s policy titled “Zero Tolerance of Resident Abuse and Neglect, #RC-02-01-01", last updated April 2017, which indicated that “all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times” and “anyone who witnessed or suspected abuse or neglect of a resident must notify management immediately”.

During a telephone interview with Inspector #627, PSW #126 stated that they had been working along side PSW #127 who was assigned to care for resident #011. PSW #126 stated that they felt PSW #127 had not provided care for resident #011. They stated that they had reported the incident at the end of the shift to RN #132, who had directed them to write the details of the incident and submit to the Director of Care (DOC) which they had done.

During an interview with Inspector #627, RN #112 stated that the home’s expectation with any allegations of abuse or neglect was that it be reported to management immediately. If it was after hours, the on call manager could be reached by telephone. They further stated that asking a PSW to write up the details of an incident and to submit it to the DOC was not the home’s policy.

During an interview with Inspector #627, the DOC stated that the alleged neglect had been substantiated, and that PSW #127 had been terminated. They further stated that it was the home's expectation that any allegation of abuse or neglect be reported to management immediately. They substantiated that the home's policy titled "Zero Tolerance of Resident Abuse and Neglect, #RC-02-01-01", last updated April 2017, was not complied with. [s. 20. (1)]

2. A Critical Incident (CI) report was submitted to the Director during a specific month in 2017, alleging staff to resident physical abuse.

The CI report indicated that PSW #113 was rough with a resident while providing care, which almost caused resident #006 to fall, then grabbed the resident by their arm causing the resident pain. This was reported by resident #006 to PSW #123. According to the CI report, PSW #123 reported the allegation of abuse to RN #112.

Inspector #684 reviewed the home's investigation notes which mirror the critical incident report. The DOC informed Inspector #684 that further investigation was not conducted as PSW #113 was working in the home under a temp agency contract with the home.

Inspector #684 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-01", updated April 2017. The policy indicated Extendicare has zero tolerance for abuse and neglect. "Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated. Abuse in relation to a resident, means physical, sexual, emotional, verbal or financial abuse."

During an interview with Inspector #684, DOC confirmed that PSW #113 has been removed from the staff list and is never to work at the facility again. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident (CI) report was submitted to the Director during a specified month in 2017, alleging staff to resident neglect. The CI report alleged that PSW #127 had not provided care to resident #011.

A review of resident #011's progress notes by Inspector #627 identified a deterioration of the resident's health condition, which indicated they were no longer independent and required extensive assistance. Inspector #627 reviewed the resident's care plan during the same period. The care plan did not indicate that the resident required extensive assistance.

During an interview with Inspector #627, RN #112 substantiated that resident #011's care plan was not reviewed and revised to reflect their care needs and the computer generated care plan had not been modified and individualized for resident #011. They stated that a care plan reflected the care a resident received and this care plan was not reflective of resident #011's care needs. [s. 6. (10) (b)]

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 that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who required end-of-life care received care in a manner that met their needs.

A Critical Incident (CI) report was submitted to the Director during a specific month in 2017, alleging staff to resident neglect. The CI report alleged that PSW #127 had not provided basic care to resident #011.

Inspector #627 reviewed the resident’s paper chart and noted Physician orders for end-of-life care.

Inspector #627 reviewed the care plan in effect and noted a foci for end-of-life care.

During a telephone interview with PSW #126, they stated that they had been working on the unit, where resident #011 resided, along with PSW #127, who was assigned to care for resident #011. PSW #126 stated they informed PSW#127, that during their shift, they had noticed resident #011 was in bed and their health condition had deteriorated to where the resident may be close to their end-of-life. Later in that shift, PSW #126 had entered resident #011’s room to offer assistance with end-of-life care. They stated that PSW #127 informed (PSW #126) that resident #011 had passed. PSW #126 stated that they felt; the resident had not been cared for and should have received care from PSW #127, because they observed end-of-life care having not been provided.

During an interview with the DOC, they stated that they had found out through the investigation that PSW #127 had not attended to resident #011 during their shift, and resident #011 had not been provided with end-of-life care.

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 that the resident who required end-of-life care receives care in a manner that meets their needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident’s substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker was promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the persons who were to be notified.

A Critical Incident (CI) report was submitted to the Director during a specific month in 2017, alleging staff to resident neglect. The CI report alleged that PSW #127 had not provided basic care to resident #011.

A review of a specific policy related to end-of-life care indicated that staff were to "Communicate with the resident and substitute decision maker (SDM) when changes in a resident's condition occur".

Inspector #627 reviewed resident #011's progress notes which revealed an entry of a call placed to the SDM when resident #011 had passed: The SDM expressed that they had received conflicting information from two different staff members regarding the health of the resident which did not reflect the resident having a serious illness.

A further review of the progress notes indicated the resident had a significant change in their health condition. The resident had a fall, post fall they were responsive and requested to be returned to bed. An assessment was completed and the results did not show any change in their condition at that time. Shortly there after, a progress note was written indicating the resident was unresponsive and their health condition was deteriorating.

During an interview with RPN #116, they stated that they had been called to assess resident #011 and found them to be unresponsive. They had reported their findings to the RN, but had not contacted the family.

A further interview with Inspector #627, RN #112 stated that, as resident #011 remained mobile the family should have been called and made aware when their condition deteriorated.

During an interview with the Inspector, the DOC stated that the family should have been made aware of the resident's change in condition. [s. 107. (5)]

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 that the resident’s substitute decision-maker were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the peon or persons who were to be notified, to be implemented voluntarily.

Issued on this 20th day of December, 2017

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

Original report signed by the inspector.

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHELLEY MURPHY (684), SYLVIE BYRNES (627)

Inspection No. / No de l'inspection : 2017_671684_0007

Log No. / No de registre : 032409-16, 013647-17, 015714-17, 015720-17, 015721-17, 016389-17, 018285-17, 018415-17, 019641-17, 020797-17, 023202-17, 024099-17, 024245-17

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Dec 11, 2017

Licensee / Titulaire de permis : EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : EXTENDICARE YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tracy Lamirande

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To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall:
a) Ensure that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with by all staff.
b) Specifically ensure that proper reporting procedures are followed.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance for abuse and neglect of residents and that it was complied with.

A Critical Incident (CI) report was submitted to the Director during a specific month in 2017, alleging staff to resident neglect. The CI report alleged that PSW #127 had not provided basic care to resident #011.

Inspector #627 reviewed the home's policy titled “Zero Tolerance of Resident Abuse and Neglect, #RC-02-01-01", last updated April 2017, which indicated that “all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times” and “anyone who witnessed or suspected abuse or neglect of a resident must notify management immediately”.

During a telephone interview with Inspector #627, PSW #126 stated that they had been working along side PSW #127 who was assigned to care for resident #011. PSW #126 stated that they felt PSW #127 had not provided care for resident #011. They stated that they had reported the incident at the end of the shift to RN #132, who had directed them to write the details of the incident and submit to the Director of Care (DOC) which they had done.

During an interview with Inspector #627, RN #112 stated that the home's expectation with any allegations of abuse or neglect was that it be reported to management immediately. If it was after hours, the on call manager could be reached by telephone. They further stated that asking a PSW to write up the details of an incident and to submit it to the DOC was not the home's policy.

During an interview with Inspector #627, the DOC stated that the alleged neglect had been substantiated, and that PSW #127 had been terminated. They further stated that it was the home's expectation that any allegation of abuse or neglect be reported to management immediately. They substantiated that the home's policy titled "Zero Tolerance of Resident Abuse and Neglect, #RC-02-01-01", last updated April 2017, was not complied with. [s. 20. (1)]
(627)

2. A Critical Incident (CI) report was submitted to the Director during a specific month in 2017, alleging staff to resident physical abuse.

The CI report indicated that PSW #113 was rough with a resident while providing care, which almost caused resident #006 to fall, then grabbed the resident by their arm causing the resident pain. This was reported by resident #006 to PSW #123. According to the CI report, PSW #123 reported the allegation of abuse to RN #112.

Inspector #684 reviewed the home's investigation notes which mirror the critical incident report. The DOC informed Inspector #684 that further investigation was not conducted as PSW #113 was working in the home under a temp agency contract with the home.

Inspector #684 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-01", updated April 2017. The policy indicated Extendicare has zero tolerance for abuse and neglect. "Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated. Abuse in relation to a resident, means physical, sexual, emotional, verbal or financial abuse."

During an interview with Inspector #684, DOC confirmed that PSW #113 has been removed from the staff list and is never to work at the facility again. [s. 20. (1)]

The decision to issue this compliance order was based on the scope which was determined to be a pattern, having affected more than the fewest number of residents that were inspected, the severity, which indicated actual harm, and the compliance history, which despite previous non-compliance issued, including three voluntary plans of correction #2017_565612_0012, #2017_565612_004, #2015_320612_0006, written notification #2016_282543_0024 and two compliance orders #2016_391603_0007 and #2015_391603_0024 non-compliance continues with this section of the legislation. (684)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Shelley Murphy

Service Area Office / Bureau régional de services : Sudbury Service Area Office