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 le Loi de 2007 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 12, 2018;	2018_657681_0003 (A1)	001851-18	Resident Quality Inspection

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

STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

Compliance Order #001 Due Date extension to April 3, 2018, requested and approved.

Issued on this 12 day of March 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): February 5-9, 2018, and February 12-16, 2018.

The following intakes were inspected during this Resident Quality Inspection:

- One intake related to CO #001 from Inspection report #2017_671684_0007, s. 20 (1) of the Long-Term Care Homes Act (LTCHA), 2007, specific to ensuring that the home's prevention of abuse and neglect policy was complied with.

- Three intakes related to complaints submitted to the Director regarding resident care concerns.

- One intake related to a missing or unaccounted for controlled substance.

- Two intakes related to allegations of staff to resident abuse.

- One intake related to an allegation of resident to resident abuse.

- One intake related to the unexpected death of a resident.

- One intake related to an incident that caused injury to a resident and resulted in transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Resident-Assessment-Instrument (RAI) Coordinators, Pharmacist, Dietary Manager, Physiotherapist (PT), Registered Dietitian (RD), Food Service Supervisors, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Rehab Assistants, Maintenance staff, Housekeeping staff, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Safe and Secure Home

Skin and Wound Care

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

9 WN(s)
4 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. 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 the policy was complied

with.

During Inspection #2017_671684_0007, compliance order (CO) #001 was issued to the home to address the licensee’s failure to comply with s. 20 of the Long Term Care Homes Act (LTCHA), 2007. The CO ordered the home to:

a) Ensure that the home’s policy to promote zero tolerance of abuse and neglect of residents was complied with by all staff.
b) Specifically ensure that the proper reporting procedures were followed.

The compliance due date of this order was December 15, 2017.

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident verbal abuse. The CIS report indicated that PSW #137 heard PSW #139 make inappropriate comments to resident #042 and that resident #042 was upset by these comments.

The Ontario Regulation 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth that was made by anyone other than a resident.

Inspector #679 reviewed the home’s internal investigation notes, which identified that ADOC #119 received a note from RPN #145. The note indicated that PSW #137 reported to RPN #145 that PSW #139 made inappropriate comments to resident #042. PSW #139 received disciplinary action as a result of the incident.

During an interview with Inspector #681, resident #042 indicated that a staff member made inappropriate comments to them of a belittling nature.

During an interview with Inspector #679, PSW #137 stated that they heard PSW #139 make inappropriate comments to resident #042 and that resident #042 was upset by these comments. PSW #137 stated that they reported the observation to RPN #145 immediately after assisting resident #042 with the remainder of their care.

During an interview with Inspector #679, RPN #145 identified that they were made aware of the allegation of verbal abuse involving resident #042 on a specified date

and time. RPN #145 identified that PSW #137 first approached them with a concern about PSW #139 at a specified time, but RPN #145 told PSW #137 to tell them about the concern after they came back from their break. RPN #145 also indicated that they reported the incident to RN #146 at a specified time.

During an interview with Inspector #681, RN #146 identified that they were not aware of the full extent of the complaint, as they were busy performing other tasks when the concern was brought forward to them by RPN #145. RN #146 stated that they could not recall exactly what information was told to them by RPN #145 or when this information was reported to them. RN #146 stated that they did not report the incident to the manager on-call or investigate the incident, as per the process outlined in the homes policy.

A review of the home's policy entitled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, identified that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect must report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The policy further indicated that in Ontario, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident was required to contact the Ministry of Health and Long Term Care.

In an interview with the DOC, they identified that the allegation of abuse towards resident #042 was substantiated and that PSW #139 received disciplinary action as a result of the incident. The DOC indicated that the expectation of the home was that allegations of abuse be reported immediately. The DOC stated that RPN #145 should have reported the allegations to RN #146 immediately and that RN #146 should have immediately reported the allegations to the on-call manager. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

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 care set out in the plan of care was provided to the resident as specified in the plan.

Resident #002 was identified as having altered skin integrity in the most recent Minimum Data Set (MDS) assessment.

Inspector #687 reviewed resident #005's care plan, which indicated that resident #005 was to receive a specified intervention by a registered staff member on two specific days of the week. Resident #005's Electronic Treatment Administration Record (eTAR) indicated that on four separate dates, the scheduled intervention was not completed.

In an interview with resident #005, the resident stated that they had altered skin integrity and that a scheduled intervention was being completed by staff.

In an interview conducted by Inspector #687, PSW #115 stated that resident #005

had altered skin integrity and that specified interventions were being completed by registered staff.

In an interview with RN #105, the RN stated that resident #005 had altered skin integrity. The RN further stated that the registered staff were completing specific interventions and that if an intervention was missed, it would be reported during shift-to-shift report and would be completed within 24 hours.

In an interview with the Wound Care Lead, they indicated that registered staff were expected to follow the interventions outlined in the resident's plan of care. If resident #005's interventions were missed, then the registered staff did not follow the plan of care for the resident. [s. 6. (7)]

2. A CIS report was submitted to the Director, which indicated that there was an altercation between resident #007 and resident #008 and that resident #008 was injured as a result of this altercation.

Inspector #687 reviewed resident #008's plan of care, which indicated that resident #008 had a history of a specified behaviour. The Inspector reviewed resident #007's care plan, which indicated that staff were to ensure that a specific intervention was in place for resident #007 at all times.

In an interview with resident #007, the resident stated that resident #008 was known to have a specified behaviour. Resident #007 further stated that they had a specific intervention in place, but that the intervention had been missing on two specific dates.

In an interview with the Inspector, PSW #141 indicated that resident #007 should have a specific intervention in place at all times. PSW #141 verified that the specific intervention was not in place as indicated in resident #007's plan of care.

In an interview with the Inspector, RPN #142 stated that resident #007 should have a specific intervention in place at all times and verified that the intervention was missing.

In an interview with the Inspector, ADOC #112 stated that resident #007 should have a specific intervention in place at all times. The ADOC stated that if the specific intervention was not in place, then care was not provided as per resident #007's the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care was 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 CIS report was submitted to the Director, related the unexpected death of resident #009.

A review of the electronic progress notes identified that resident #009 was started on specific infection prevention and control (IPAC) interventions.

Inspector #679 reviewed the electronic care plan that was in place at the time of the resident’s death. The care plan did not indicate that there were specific IPAC interventions in place.

A review of the home's policy outlined that registered staff were to ensure that the care plan and progress notes were updated accordingly once it was determined that specific IPAC interventions were required. Further, the policy indicated that registered staff were to ensure that each discipline reviewed the resident’s care plan to determine what changes to the plan of care were required to meet all of the resident’s care needs while the specific IPAC interventions were in place.

During an interview with RPN #129, they identified that they were providing care to resident #009 prior to their death and that there were specific IPAC interventions in place. RPN #129 identified that when a resident had specific IPAC interventions in place, they would be identified during shift report and in the resident's care plan.

In an interview with RN #105, they indicated that they assessed resident #009 prior to their death, and that specific IPAC interventions were in place. Inspector #679 and RN #105 reviewed the resident's electronic care plan that was in place at the time of resident #009’s death. RN #105 stated that there was no focus to indicate that specific IPAC interventions were in place and that the care plan should have been updated immediately to reflect these specific interventions.

In an interview with the DOC, they identified that they had reviewed resident #009’s care plan and that there was no indication in the care plan that specific IPAC interventions were in place. The DOC stated that when specific IPAC interventions are in place, they should be identified in the resident's care plan. Further, the DOC

identified that a resident's care plan should be updated with any change in condition or new diagnosis. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

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

A CIS report was submitted to the Director about an incident that caused injury to a resident and resulted in transfer to hospital. The CIS report indicated that resident

#014 was using a mobility aid when they became injured.

Inspector #681 reviewed resident #014's paper health care chart, which included a physician note and order that indicated that resident #014 was to have a specified diagnostic test.

During an interview with Inspector #681, RN #116 verified that a physician order for a specified diagnostic test was written on a specific date. However, RN #116 stated that because the DOC clerk was absent from the home, the diagnostic test was not booked until five days later, when RN #116 booked the appointment themself.

During an interview with the DOC, they indicated that there was a delay in booking resident #014's diagnostic test because RN #140 did not follow the proper process for notifying the DOC clerk about the required appointment nor was the correct procedure followed given the absence of the DOC clerk. The DOC stated that the diagnostic test should have been booked within 24 hours of the physician's order being written. The DOC verified that there was a delay in implementing an intervention outlined in resident #014's plan of care. [s. 24. (6)]

2. The licensee has failed to ensure that the resident was reassessed and the care plan was reviewed and revised when the resident's care needs change.

A CIS report was submitted to the Director about an incident that caused injury to a resident and that resulted in them being transferred to hospital. The CIS report indicated that resident #014 was using a mobility aid when they became injured.

Inspector #681 reviewed resident #014's most recent care plan, which indicated that resident #014 required a specified level of assistance from staff for transfers. Resident #014's care plan also did not include the use of a specified device on the resident's mobility aid.

During an interview with the Inspector, resident #014 stated that a specified device was always present on their mobility aid.

During an interview with the Inspector, PSW #144 stated that, since being injured, resident #014 required a different level of assistance from staff for transfers. PSW #144 also stated that resident #014 had a specified device on their mobility aid. PSW #144 stated that resident #014's care plan was not updated to reflect the resident's current needs related to transfer status, toileting, and mobility.

During an interview with the Inspector, RPN #123 indicated that resident #014's care plan was not updated after they became injured and that it should have been updated to reflect the resident's change in status.

During an interview with the Inspector, the DOC stated that resident #014 should have been reassessed and their care plan updated after they were transferred back from the hospital. [s. 24. (9)]

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 care set out in the care plan was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

During resident interviews, residents #016, #021, #022, #023, and #024, indicated that food and fluids were not always served at an appropriate temperature.

On February 9, 2018, Inspector #681 observed the breakfast meal in a specific dining room. When the Inspector entered the dining room at 0840 hours, beverage carts containing milk, were already set up in the dining room. Following the completion of breakfast service, the Inspector observed that the beverage carts were still in the dining room at 0955 hours. Accompanied by the Inspector, Food Service Supervisor #126 took the temperature of an unopened one litre container of skim milk from the beverage cart. A temperature of 43.2 degrees Fahrenheit was recorded.

On February 12, 2018, at 1004 hours, Inspector #681 observed a beverage cart in a specified dining room that contained a one litre container of lactose free milk and two jugs of two percent milk. Accompanied by the Inspector, Dietary Manager #127 took the temperature of the lactose free milk. A temperature of 46.0 degrees Fahrenheit was recorded.

Inspector #681 reviewed the home's policy titled "Holding and Distribution of Food" last updated November 2016, which indicated that cold foods are to be held at a temperature below 40 degree Fahrenheit for no longer than two hours.

During separate interviews with Inspector #681, Food Service Supervisor #126 and Dietary Manager #127 both stated that milk needed be held at a temperature of less than 40 degrees Fahrenheit. Dietary Manager #127 also stated that milk should be immediately refrigerated after the completion of meal service. [s. 72. (3) (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 food and fluids are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

During a supper dining observation, Inspector #681 observed PSW #137 serve supper to residents #038 and #039 at 1735 hours. Residents #038 and #039 were both seated at the same table. PSW #137 began to assist residents #038 and #039 with their meal, however, PSW #137 left the table at the following times to complete other tasks:

- From 1738 to 1739 hours, 1741 to 1744 hours, 1748 to 1749 hours, and 1750 to 1752 hours, PSW #137 assisted resident #041.
- At 1757 hours, PSW #137 assisted resident #040.
- From 1758 hours to 1759 hours, PSW #137 went and spoke with RPN #138.
- From 1759 hours to 1801 hours, PSW #137 assisted resident #040.
- At 1805 hours, PSW #137 removed an item that was on another table.

Inspector #681 observed that both residents #038 and #039 had their plates removed with only a specified portion of their supper meal consumed.

During this meal service, Inspector #681 also observed resident #040, who was seated at the same table, be assisted with their supper meal by PSW #139. After resident #040 finished eating their supper meal, PSW # 139 left the table and went to assist other residents in the dining room. At 1759 hours, Inspector #681 observed that resident #040 was crying.

In an interview with the Inspector, PSW #137 stated that they, along with another PSW, were responsible for the residents at three specified tables in the dining room. PSW #137 reported that, at one of these tables, there were three residents who required feeding assistance. However, at supper, there was usually only one staff to feed all three residents. PSW #137 stated that resident #040 had grabbed a cup containing fluids of an inappropriate consistency and this caused them to choke, which was why the resident was crying.

During an interview with the Inspector, RPN #138 stated that a staff member should only assist two residents at a time with their meal. However, RPN #138 stated that a challenge at supper was that there was only one PSW assigned to a specified table and that there were three residents seated at this table who required feeding assistance. RPN #138 stated that it was reported to her by PSW #137 that during the supper meal resident #040 got a hold of fluid that was of an inappropriate consistency and that the resident had choked on this fluid.

Inspector #681 reviewed the care plans for residents #038 and #039, which indicated that staff were to provide a specified level of assistance at meals and nourishments. The Inspector also reviewed the care plan for resident #040, which indicated that they were to receive a specified level of assistance from staff at meals and nourishments and that they were to receive a specified fluid consistency.

Inspector #681 reviewed the home’s policy titled “Meal Service”, last updated February 2017, which indicated that fluids and meals should be served to residents requiring assistance only when someone was available to provide the required assistance.

During an interview with the Inspector, the DOC stated that it was the home’s expectation that staff remain with residents when assisting them with a meal and

that PSW #137 should have not gotten up to assist other residents until resident #037 and #038 had finished eating their meal. [s. 73. (2) (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 residents who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Long-Term Care Homes Act (LTCHA) or Ontario Regulation (O. Reg) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg 79/10 s. 68. (2) (e) (ii), the licensee was required to ensure a weight monitoring system to measure and record, with respect to each resident, body mass index and height upon admission and annually thereafter.

Through record reviews, Inspectors #679, #681, and #687 identified that residents #025, #026, #027, #028, #029, #030, #031, #032, #033, #034, #035, #036, and #037 had not had a height completed since 2016.

During an interview with the Inspector, RD #136 stated that heights should be completed annually and verified that an annual height had not been completed for residents #025, #026, #027, #028, #029, #030, #031, #032, #033, #034, #035, #036, and #037.

Inspector #681 reviewed the home's policy titled Height and Weight Monitoring, last updated February 2017, which indicated that residents are to have their height measured and documented upon admission and annually thereafter, or whenever a significant change occurs.

During an interview with ADOC #119, they indicated that that all residents should have a height completed on a yearly basis. [s. 8. (1)]

WN #7: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident: a missing or unaccounted for narcotic.

Inspector #679 reviewed the medication incident reports for a three month period. It was identified on a medication incident report that on a specified date, Pharmacist #130 identified that there were no wasted (used) transdermal patches in the narcotic destruction box, and that there should have been three wasted patches.

Inspector #679 reviewed the Ministry of Health and Long-Term Care’s online critical incident reporting portal and noted that CIS reports had not been submitted to the Director regarding the missing transdermal patches.

Inspector #679 reviewed the policy entitled "Mandatory and Critical Incident Reporting: RC-09-01-06" last revised in April 2017. The policy outlined that the Director of Care/ Designate was to inform the MOH Director no later than one business day after the occurrence of the incident of: a missing or uncontrolled substance.

In an interview with the DOC, they identified that they came to the home to investigate the incident. The DOC and Inspector #679 reviewed the online critical incident reporting portal and were unable to identify that a CIS report was submitted to the Director for the missing transdermal patches. The DOC indicated that in any instances of unaccounted for narcotics, a report should be submitted to the Director. [s. 107. (3) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored was restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Inspector #679 observed the overstock medication that was kept in the home. Inspector #679 identified that the government stocked medication was stored on an open shelf in DOC Clerk #113's office.

In an interview with DOC Clerk #113 they identified that they were not a member of the registered staff. DOC Clerk #113 identified that they, maintenance, registered staff and management had a key to their office.

In an interview with maintenance staff #122 they identified that they had a key to DOC Clerk #113's office. Inspector #679 observed maintenance staff #122 unlock DOC Clerk #113's office using a key from their key ring.

In an interview with the DOC they identified that the overstock medication was kept in DOC Clerk #113's office, and that the DOC Clerks have always had access to the medication as they were responsible for stocking medication. The DOC identified that the DOC Clerk was not a member of the registered nursing staff. [s. 130. 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On three specified dates, Inspector #687 observed that resident #018 and #019 had a personal protective equipment (PPE) supply bag but no precaution isolation signage to indicate what type of PPE was required for interacting with the isolated resident.

A review of the home's policy titled "Isolation" last updated September 2017, indicated the following under procedures for Registered Staff:
- Place required personal protective equipment (PPE) outside the resident's door. Also ensure that signage was placed on the door of the resident's room requiring visitors to check with the nurse before entering the room. Signage would also include the kind of precautions in place and the PPE required to provide care for the resident.

In an interview conducted by Inspector #687, PSW #102 identified that resident #019 was on isolation and that the staff were made aware of isolation precautions during shift to shift report. PSW #102 stated that specified precautions were required when completing care and that staff were required to perform hand hygiene before and after each encounter with the isolated resident.

In an interview conducted by Inspector #687, PSW #100 stated that resident #018 was on isolation and that the resident should have signage on their doorway indicating isolation precautions. The PSW further indicated that resident #018's isolation status was captured in their electronic care plan and reviewed during shift to shift report.

During an interview conducted by Inspector #687, RPN #101 indicated that resident #019 was on isolation and that isolation signage should be posted on their door to identify the type of PPE required and to prevent transmission of infection to other residents, staff, and visitors.

In an interview conducted by Inspector #687, the Infection Prevention and Control (IPAC) lead verified that residents #018 and #019 were on isolation. The IPAC lead further stated that they were unaware that resident #018 and #019 did not have isolation signage posted on their door. The IPAC lead indicated that the isolation signage was required to identify the type of PPE required and prevent infection

transmission to other residents, staff and visitors. [s. 229. (4)]

2. During a supper dining observation, Inspector #681 observed PSW #137 assist resident #038 and resident #039 with their supper meal. Inspector #681 observed PSW #137 get up from the table to assist other residents on eight separate occasions during the meal service. Inspector #681 did not observe PSW #137 complete hand hygiene once throughout the meal service.

During an interview with Inspector #681, PSW #137 stated that the expectation was that they sanitize their hands between assisting residents. PSW #137 acknowledged that they did not complete appropriate hand hygiene when assisting residents in the dining room during supper meal service.

During an interview with the Inspector, RPN #138 reported that it is the expectation that staff wash their hands every time they go from assisting one resident to assisting another resident.

Inspector #681 reviewed the home’s policy titled “Hand Hygiene” last updated September 2017, which indicated that hand hygiene was required after contact with any resident.

During an interview with the Inspector, the DOC stated that it is the home’s expectation that staff perform hand hygiene between assisting residents. [s. 229. (4)]

Issued on this 12 day of March 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : STEPHANIE DONI (681) - (A1)

Inspection No. / No de l'inspection : 2018_657681_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 001851-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 12, 2018;(A1)

Licensee / Titulaire de permis :
Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 700, 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

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)

Linked to Existing Order / Lien vers ordre existant: 2017_671684_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 must be compliant with s. 20. (1) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must

a) ensure that all employees who witness or suspect that a resident is being abused or neglected immediately report the allegations as per the home's policy

b) develop and implement a process to ensure that staff are aware of what constitutes resident abuse and neglect and that they are aware of the appropriate process for reporting these allegations.

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 the policy was complied with.

During Inspection #2017_671684_0007, compliance order (CO) #001 was issued to

the home to address the licensee's failure to comply with s. 20 of the Long Term Care Homes Act (LTCHA), 2007. The CO ordered the home to:

a) Ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with by all staff.
b) Specifically ensure that the proper reporting procedures were followed.

The compliance due date of this order was December 15, 2017.

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident verbal abuse. The CIS report indicated that PSW #137 heard PSW #139 make inappropriate comments to resident #042 and that resident #042 was upset by these comments.

The Ontario Regulation 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that was made by anyone other than a resident.

Inspector #679 reviewed the home's internal investigation notes, which identified that ADOC #119 received a note from RPN #145. The note indicated that PSW #137 reported to RPN #145 that PSW #139 made inappropriate comments to resident #042. PSW #139 received disciplinary action as a result of the incident.

During an interview with Inspector #681, resident #042 indicated that a staff member made inappropriate comments to them of a belittling nature.

During an interview with Inspector #679, PSW #137 stated that they heard PSW #139 make inappropriate comments to resident #042 and that resident #042 was upset by these comments. PSW #137 stated that they reported the observation to RPN #145 immediately after assisting resident #042 with the remainder of their care.

During an interview with Inspector #679, RPN #145 identified that they were made aware of the allegation of verbal abuse involving resident #042 on a specified date and time. RPN #145 identified that PSW #137 first approached them with a concern about PSW #139 at a specified time, but RPN #145 told PSW #137 to tell them about the concern after they came back from their break. RPN #145 also indicated that

they reported the incident to RN #146 at a specified time.

During an interview with Inspector #681, RN #146 identified that they were not aware of the full extent of the complaint, as they were busy performing other tasks when the concern was brought forward to them by RPN #145. RN #146 stated that they could not recall exactly what information was told to them by RPN #145 or when this information was reported to them. RN #146 stated that they did not report the incident to the manager on-call or investigate the incident, as per the process outlined in the homes policy.

A review of the home's policy entitled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, identified that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect must report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The policy further indicated that in Ontario, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident was required to contact the Ministry of Health and Long Term Care.

In an interview with the DOC, they identified that the allegation of abuse towards resident #042 was substantiated and that PSW #139 received disciplinary action as a result of the incident. The DOC indicated that the expectation of the home was that allegations of abuse be reported immediately. The DOC stated that RPN #145 should have reported the allegations to RN #146 immediately and that RN #146 should have immediately reported the allegations to the on-call manager.

The severity of this issue was determined to be a level three, as there was actual harm to the residents of the home. The scope of the issue was a level one, as it only related to one resident reviewed. The home had a level four compliance history, as they had ongoing non-compliance with this section of the LTCHA that included:

- voluntary plan of correction (VPC) issued May 22, 2015, (#2015_320612_0006);

- compliance order (CO) #003 issued October 22, 2015, with a compliance due date (CDD) of December 2, 2015, (#2015_391603_0024);

- CO #003 issued August 30, 2016, with a CDD of September 30, 2016, (#2016_391603_0007);

- written notification (WN) issued October 25, 2016, (#2016_282543_0024);

- VPC issued May 4, 2017, (#2017_565612_0004);

- VPC issued July 13, 2017, (#2017_565612_0012);

- CO #001 issued December 11, 2017, with a CDD of December 15, 2017, (#2017_671684_0007). (679)

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

Apr 03, 2018(A1)

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 12 day of March 2018 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : STEPHANIE DONI - (A1)

Service Area Office / Bureau régional de services : Sudbury