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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2017	2017_572627_0005	003695-17, 004068-17, 004174-17, 004961-17	Complaint

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 Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

SYLVIE BYRNES (627)

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): March 15 -17, 2017, and March 20 -22, 2017.

This complaint inspection is related to:

Two Complaints submitted to the Director regarding resident care;
One complaint submitted to the Director regarding staffing shortages; and
One complaint submitted to the Director regarding falls.

A Critical Incident System inspection #2017_572627_0007 and a Follow Up inspection #2017_572627_0006 were conducted concurrently with this inspection.

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

The Inspector also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staffing schedules, staff training records, internal investigations, policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' wheelchairs were kept clean and sanitary.

A complaint was submitted to the Director, alleging that staffing shortages were affecting resident care.

During a tour of the home, Inspector #627 observed crusted food and dust on chair frames, seat covers, foot pedals, back rests and wheels, on 17 residents' wheelchairs.

During an interview with the Inspector, PSW #126, 125, 127, 128, 119 and RPN #128 confirmed that the wheelchairs had accumulated dried crusted food on them and needed a thorough cleaning. They stated that there was a schedule for the cleaning of chairs which was completed on the night shift by the float PSW on every floor. They further stated that since the home was often short staffed on nights, the float PSW was expected to go to the other floors to assist other staff members with resident care, therefore, the chairs were often not cleaned as per schedule. As well, PSW #119 and #129 stated that the night shift was often staffed with modified workers which may or may not be able to assist with patient care and secondary tasks such as cleaning of the chairs.

During an interview with the DOC, they stated that the expectations were that the residents' chairs be cleaned once a week and as needed during the day by the PSWs. If the night shift PSWs had not completed the task, or if a resident's chair appeared to be dirty, the expectation was for the chair to be cleaned at that time. The DOC confirmed that it was not acceptable to have residents sit in dirty chairs. [s. 15. (2) (a)]

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 residents' wheelchairs are kept clean and sanitary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions was documented.

A complaint was submitted to the Director, alleging that the resident was not receiving the personal care they required.

During an interview with Inspector #627, the complainant stated that they had often visited resident #002 and had found that the resident had not been provided with care. The staff had stated that the resident had refused assistance with their care needs and displayed responsive behaviours when the staff insisted on providing support. The complainant stated that they were aware that the resident often refused assistance,

however, they felt that simply accepting that the resident regularly refused care was not enough. They wanted the staff to attempt different approaches to ensure the resident received the care that they required.

During an interview with the Inspector, resident #002 stated that they completed their care independently or with some assistance from the staff when they felt able, however, they had not completed their care or accepted assistance when they felt unable to. They further stated that when a certain intervention was provided to them, they had a period of time when they were able to complete many of their activities of daily living (ADLs). The resident stated that they often declined care, and that their best time a specific type of care was during a specific time of the day. When the Inspector inquired why the resident had not attended meal time in the dining room, they stated that a certain intervention was not provided to them in time to allow them to attend the dining room.

The Inspector reviewed the home's policy titled "Responsive Behaviours" #09-05-01, dated September 2010, which identified behaviours as: physical behaviours, verbal abuse, socially inappropriate and resisting care. If a behaviour was observed, a more in depth assessment of the behaviour was to be undertaken using any one or a combination of the following tools: dementia observation scale, Cohen Manfield Agitation Inventory, responsive behaviour record and tools used by the local psychogeriatric outreach/support program. Once the assessment period was completed, registered staff were to develop a care plan which included triggers to behaviours, ways to complete a task or ADL that minimized the likelihood of the behaviour appearing, what the behaviour actually was, interventions to deal with the behaviour describing a few successful interventions for the resident, what to do when the interventions were ineffective and/or if the behaviour escalated and fluctuations in the resident's behaviour, including times when the behaviour was more prevalent and times when the behaviour was non-existent.

Inspector #627 reviewed resident #002's current care plan which listed directions that staff were to provide assistance with care and to identify cause of the behaviour, monitor episodes, consult physician and other outside recourses as needed.

During an interview with the Inspector, PSW #109 stated that resident #002's care needs were inconsistent. At times, the resident was independent and at other times they required extensive assistance for all their ADLs. They further stated that the resident often refused assistance with their care, and demonstrated responsive behaviours. For this reason, the PSWs often had not attempted to provide care to the resident. PSW

#109 stated that when resident #002 refused care, the PSWs left and re-approached the resident at a later time. If the resident refused care a second time, the care was not provided. PSW #109 stated the resident's health had deteriorated. They further stated that the resident was refusing care more often and that the care plan had not been revised to offer new strategies.

During an interview with the Inspector, PSW #107,stated that the resident's health had declined. They stated that the resident often had symptoms, and that they declined all assistance during those periods. PSW #107 stated that when the resident had severe symptoms, they often displayed responsive behaviours towards them, however, when their symptoms subsided, after they received a specific intervention, the resident was more accepting of care. They further stated it was essential that the resident be offered assistance when they were relatively symptom free as this greatly improved the chances of the resident being accepting of care.

During an interview with the Inspector, the Assistant Director of Care (ADOC) confirmed that no in depth assessment of the behaviour had been undertaken using any one or a combination of the following tools: dementia observation scale, Cohen Manfield Agitation Inventory, responsive behaviour record and tools used by the local psychogeriatric outreach/support program. They further stated that Behavioural Supports Ontario (BSO) had been involved with the care of resident in 2015, however, they had discharged the resident from their care. They confirmed that no further actions had been taken to respond to resident #002's needs. [s. 53. (4) (c)]

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 actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: 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).

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.

A complaint was submitted to the Director on February 17, 2017, alleging that resident #002 was not receiving the personal care that they required. Please see WN #02 for details.

During an interview with Inspector #627, resident #002 stated that they often refused care when their symptoms were too severe. The resident further stated that when they received a specific intervention, they were more capable of completing their activities of daily living (ADL). They further stated that staff were often late with administering the specific intervention which affected their symptoms greatly.

A review by the Inspector of a written report from a specific Physician consultation indicated that "one of the issues that they (resident #002) was dealing with was that they demonstrated responsive behaviours toward the nursing staff at the facility because they had not provided them with a specific intervention, on time. There was evidence that the intervention had been provided 20 to 30 minutes late on many days, and although that had not seemed significant on the surface, it had affected them quite a bit.

The Inspector reviewed resident #002's electronic record and identified that the specific intervention was to be provided six times daily, at specific times of the day.

The Inspector reviewed the care plan in effect at the time of the inspection which

revealed an intervention to provide the specific intervention specific times as ordered and earlier if the resident so desired. Staff were to coordinate with each other to ensure that the specific intervention was provided at specific times as much as possible ie. Call RN to assist with other responsibilities if needed to ensure that the specific intervention was provided on time.

The Inspector reviewed a specific electronic report and identified for a specified period of time, the report revealed that for 45 of 90 days, or for 50% of the days, the specific intervention was provided late on one or more occasion throughout the day.

During an interview with the Inspector, the pharmacist stated that the specific intervention had to be provided at the specified times. They further stated that a half hour difference would have caused a difference in the patient's response.

During an interview with the Inspector, the Director of Care (DOC) confirmed that the specific intervention had been provided at the different times, instead of the specified times, and that the care had not been provided to resident #002 as specified in the plan of care.

No further action will be taken in regards to this non-compliance as there is currently an outstanding order for s. 6. (7) in Complaint Report #2016_562620_0030. [s. 6. (7)]

2. 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 change or care set out in the plan was no longer necessary.

A complaint was submitted to the Director on March 1, 2017. The complainant had concerns regarding the numerous falls that resident #001 had experienced.

Inspector #627 reviewed the care plan in effect at the time of the inspection which revealed specific interventions for the focus of falls.

During an interview with the Inspector, resident #001 was observed in their room, in a certain way, utilizing specific equipment.

During an interview with Inspector #627, RPN #103 stated that the resident had certain equipment, however, two of the pieces of equipment listed in the resident's plan of care were no longer in use. The RPN confirmed that the care plan had not been revised when

the care was no longer necessary. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six month and at any other time when care set out in the plan had not been effective.

A complaint was submitted to the Director alleging that the resident was not receiving the personal care they required.

During an interview with Inspector #627, the complainant stated that they had often visited resident #002 and had found that the resident had not been provided with personal care. The staff had informed the family that resident #002 had refused assistance with their care needs and displayed responsive behaviours when the staff insisted on providing support. The family member stated that they were aware that the resident often refused assistance, however, they felt that simply accepting that the resident regularly refused care was not enough. They wanted the staff to attempt different approaches to ensure the resident #002 received the care that they required.

During an interview with the Inspector, resident #002 stated that they completed their care independently or with some assistance from the staff when they felt capable. They further stated that when they received a specific intervention, they had a period of time when they were able to complete many of their activities of daily living (ADLs). The resident stated that they often declined care because of their symptoms.

The Inspector reviewed the "PSW documentation in the Daily Care Flow sheet" for a specified period of time which revealed that resident #002 had refused specific care 55 percent of the time. The Inspector also noted multiple entries of refusal for care during the same period of time.

Inspector #627 reviewed resident #002's current care plan which listed specific care that directed staff to re-approach the resident if they refused care.

During an interview with the Inspector, PSW #109 stated that when resident #002 refused care, the PSWs left and re-approached the resident at a later time. If the resident refused care a second time, the care was not provided.

During an interview with the Inspector, RPN #103 stated that resident #002 was capable of completing their personal care independently at times, however, when they required

assistance to complete their personal care, they often refused the help of PSWs. The RPN further stated that the refusing of care was a frustration for the staff and that the staff couldn't force them to accept care. The PSWs utilized the "stop and go" approach; the PSWs left if the resident refused care and attempted to provide care at a later time. If the resident refused, the care was not provided and the substitute decision maker was notified. PSW #109 stated that the "stop and go approach" was the only strategy used and that it often was not effective.

During an interview with the Inspector, the Assistant Director of Care (ADOC) confirmed that resident #002 had not been reassessed and the plan of care had not been revised when the care set out in the plan of care had not been affective. [s. 6. (10) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team who provided a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker (SDM) if any.

A complaint was submitted to the Director which itemized many care concerns.

During an interview with Inspector #627, the complainant stated that the resident's first care conference was held months after the resident was admitted to the home. They further stated that the staff member overseeing the care conference seemed unprepared.

The Inspector reviewed resident #003's electronic records which identified the specific date that resident #003 was admitted to the home.

The Inspector reviewed resident's #003's progress notes which revealed that an interdisciplinary care conference was held, 29 weeks after the resident's admission to the home. The interdisciplinary care conference was attended by family members of resident #003, a registered nurse (RN), a support service worker, an activity worker, a dietician, and a physiotherapist.

During an interview with the Inspector, the DOC confirmed that the first Interdisciplinary Care Conference for resident #003 was held on 29 weeks after the resident's admission to the home. They further stated that it should have been held within six weeks of the resident's admission. [s. 27. (1) (a)]

Issued on this 25th day of May, 2017

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

Original report signed by the inspector.