Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 10, 2017;	2017_655679_0004 (A1)	007599-17	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 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

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MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Attached is the amended Public Inspection Report with the extended compliance due date for CO #002 as requested by the Administrator.

Issued on this 10 day of August 2017 (A1)

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

Original report signed by the inspector.

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MICHELLE BERARDI (679) - (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): May 1-5 and 8-12, 2017.

Additional logs inspected during this RQI include:

-Follow-Up log, related to compliance order #002 issued during inspection #2016_562620_0030 regarding S.6 (7), care not being provided as specified in the plan of care;

-One other log, related to deferred inspection items during inspection 2016_395613_0007;

-Five complaints submitted to the Director related to the care of residents;

-Six critical incidents submitted to the Director related to resident falls;

-Nine critical incidents submitted to the Director related to allegations of staff to resident abuse and neglect;

-Two critical incidents submitted to the Director related to duty to protect residents from abuse and neglect;

-One critical incident submitted to the Director related to allegations of resident to resident abuse; and

-One critical incident submitted to the Director related to missing narcotics.

During the course of the inspection, the inspector(s) spoke with the Regional Director, Administrator, Director of Care, Assistant Director of Care, Food Services Manager, Registered Dietitian, Physiotherapist, Resident Assessment Instrument/ Minimum Data Set (RAI/MDS) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **8 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **1 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 of abuse and neglect of residents and that it was complied with.

A Critical Incident (CI) report was submitted to the Director, alleging staff to resident physical abuse. The CI report indicated that on a particular day, PSW #110 had performed a forceful action to the resident as reported by PSW #111. According to the CI report, PSW #111 reported the allegation of abuse to RPN #146 the following day.

Inspector #542 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02", updated April 2016. The policy indicated that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

In an interview with Inspector #542, PSW #124 indicated that staff were to report any allegations of suspected or witnessed abuse to their supervisor.

Inspector #542 interviewed the DOC, who acknowledged that PSW #111 did not report the alleged abuse immediately and that they reported it one day later.

2. A CI report submitted to the Director, alleged that resident #015 was found sitting in the common area of their home unit when RPN #136 arrived on a particular day. When RPN #136 questioned PSW #120 about resident #015, PSW #120 indicated that they had not assisted the resident for the duration of their shift.

a) In a review of resident #015's progress notes written by RPN #136, Inspector #679 identified that resident #015 was received on a particular day, incontinent of urine with altered skin integrity.

Inspector #679 reviewed a letter submitted to the DOC by PSW #137, which indicated that resident #015 was found in a saturated incontinence product, with altered skin integrity.

A review of the internal investigation notes indicated that PSW #120 received a written warning for not providing care for resident #015, leaving the resident unassisted with altered skin integrity.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02" last revised April 2016, identified that "All

staff must protect the rights of each resident entrusted in their care".

During an interview with the home's Assistant Director of Care (ADOC), they indicated that the neglect of resident #015 by PSW #120 was substantiated through the home's investigation.

b) A review of the CI report indicated that the incident of neglect was reported to the Director one day after the incident occurred.

In an interview with the home's ADOC, they indicated that the registered staff member did not immediately report the allegations of neglect towards resident #015, as specified in the home's policy, but rather waited until the following day.

3. A CI report submitted to the Director, outlined an alleged incident of staff to resident verbal abuse. The CI report outlined that PSW #139 entered resident #029's room and witnessed PSW #140 yelling at resident #029.

Inspector #642 reviewed the home's internal investigation notes, and found written documentation, which outlined that PSW #139 confirmed that they had not informed the RN/Supervisor in charge at the time of the alleged verbal abuse.

During an interview with Inspector #642, PSW #139 indicated that they had witnessed the incident of alleged abuse between PSW #140 and resident #029, however, did not report the incident until the next day.

Inspector #642 conducted an interview with the DOC, who indicated that it was the expectation of the home that all suspected incidents of abuse should be reported immediately to the designate in order to initiate the appropriate investigations and protect the residents from harm.

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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 plan of care was based on an assessment of the resident and the resident's needs and preferences.

A complaint was submitted to the Director, outlining concerns related to improper care of resident #013, resulting in injury.

Inspector #609 reviewed resident #013's health care records and found within the progress notes that on a particular day, PSW #108 was assisting resident #013 when the resident's limb became caught in their mobility aid. The following day, an injury was noted to the resident's limb.

During an interview with RPN #109 they verified that they were present and

working on that particular day and found that resident #013's assistive device was not applied to the mobility aid, which allowed for the resident's limb to get caught.

A review of the Minimum Data Set (MDS) assessments for resident #013 found that the resident required mobility assistance.

A review of Physiotherapist #112's assessment of resident #013 indicated that the resident utilized a mobility aid.

During an interview with Physiotherapist #112 they verified that resident #013 was assessed by a physiotherapist as requiring a mobility aid. The Physiotherapist further stated that the resident required mobility assistance and they required an assistive device to prevent injury. Physiotherapist #112 further indicated that if a resident required a high level of assistance with mobility, then the assistive device was to be used.

A review of resident #013's plan of care in effect at the time of the injury, found no mention that the assistive device was to be used. The plan of care was not updated until 10 days after the resident was injured, to include the assistive device.

2. 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 Compliance Order (CO) #002 was issued to the home on February 27, 2017, related to the licensee's failure to comply with s. 6. (7) of the LTCHA, 2007, c. 8 during critical incident inspection #2016_562620_0030 (A1).

The CO required the licensee to review all care plans for residents who were identified as being at a specific level of risk for falls, to ensure they were receiving care as specified within their plans of care, and that the residents' plans of care accurately reflected their assessed needs.

Full compliance with the CO was expected by March 31, 2017.

Inspector #679 reviewed a CI report submitted to the Director. The CI report described that resident #001 had a fall on a particular day, that resulted in a significant change which required the resident to be admitted to the hospital. The fall resulted in an injury. The CI report further indicated that resident #001 fell again the day that they returned from the hospital.

A review of the current electronic care plan, identified that resident #001 was to have a particular fall prevention device applied to their bed and a fall prevention device applied to their mobility aid, to alert staff if resident #001 was attempting to self-transfer.

During an observation of the resident, Inspector #679 noted the resident asleep in bed, with no fall prevention devices in place.

In an interview with RPN #144, they confirmed that resident #001 did not have either of the fall prevention devices in place and that there should have been one applied as outlined in their care plan. [s. 6. (7)]

3. a) A Critical Incident (CI) report was submitted to the Director indicating that resident #035 fell and was transferred to the hospital with an injury.

Inspector #609 reviewed resident #035's last two fall risk assessments and found that the resident was at a risk for falls.

Since the fall with accompanying injury on a particular day, resident #035 had a number of additional falls.

A review of resident #035's current plan of care indicated fall prevention interventions, related to the use of a mobility aid and required care to mitigate the risk of falls.

The Inspector observed resident #035 sitting in the unit's common area. The resident did not have their mobility aid near them. In the resident's room a mobility aid was noted. The Inspector also observed that the resident was assisted to the dining room for lunch by PSW #145, without the use of a mobility aid.

During an interview with PSW #145, they indicated that resident #035 was to receive specific care. PSW #145 verified that the resident did not receive the care.

Further observations of resident #035 found the resident in bed, with the bed not set up in the manner that was indicated in the resident's plan of care to mitigate falls.

During an interview with the DOC, they verified that care as specified in the plan

was to be provided to the resident, and that this did not occur with resident #035 as it related to interventions for specific care, to mitigate fall risk/injury and the use of the resident's mobility aids.

b) On a certain date, resident's #027, #035 and, #037 were noted by Inspector #609 to have an indicator outside of their room.

A review of all three residents' last fall risk assessment indicated they were at a specific level of risk for falls.

A review of the home's memorandum to all nursing staff dated November 2016, indicated that residents identified in the falls program were to have an indicator applied to their doors as well as their mobility or gait aid.

Further observations of the three residents' bedrooms found no indicator applied to their mobility aid.

During an interview with the DOC, they verified that any resident identified as being at a certain risk for falls were to be identified through the home's program and have a identifier applied to the resident's door and mobility aid.

4. 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.

Inspector #620 reviewed a CI report submitted to the Director. The CI report described that resident #030 had a fall that resulted in a significant change which required the resident to be admitted to the hospital. The fall resulted in an injury.

Inspector #620 reviewed the resident's electronic progress notes and identified that the resident had experienced a number of falls over a three month period.

Inspector #620 reviewed a document titled, "Falls Prevention and Management Program-RC-06-04-01" last revised in May, 2016. Under the heading of, "Procedures" subheading, "Interdisciplinary Team Prevention of Falls" the document indicated that staff were to create an, "individualized plan addressing identified fall causes and risk factors such as but not limited to: history of falls… gait balance and mobility, and transfers…" The document also advised staff to

refer, at risk residents to a multidisciplinary team including the physiotherapist, and to update the care plan as necessary.

A review of the assessments conducted by the home's Physiotherapy Department indicated that resident #030 had experienced a number of falls within the span of several days. The assessment also indicated that at the time of the assessment the resident ambulated independently. As a result of the assessment, the resident was determined to have had a deterioration in their mobility; therefore, the physiotherapist indicated that the resident required the use of a mobility aid.

A review of the resident's plan of care, active at the time of the resident's fall, did not indicate that the resident required the use of a mobility aid; rather, the care plan indicated that resident #030 was, independent with mobility.

Inspector #620 and the home's Resident Assessment Index/Minimum Data Set (RAI/MDS) Coordinator reviewed resident #030's care plan that was active at the time of their fall resulting in an injury, to determine if the use of the mobility aid as prescribed by the physiotherapist had been included in the care plan. After a review of the care plan the RAI/MDS Coordinator stated that the use of the mobility aid should have been included in the care plan but it was somehow omitted.

Inspector #620 interviewed the DOC who indicated that resident #030's care plan should have been revised to include the use of a mobility aid as prescribed by the home's physiotherapist. They indicated that the home's fall management program required that when a new fall prevention intervention was implemented, that it was updated in the resident's plan of care.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 ensuring that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the following rights of residents were fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A CI report submitted to the Director alleged that during the care of resident #016, PSW #138 performed an action, which caused resident #016 to feel like they were being ignored.

A review of the electronic progress notes, identified that resident #016 requested to speak with a RN regarding an incident which occurred. The progress note outlined that PSW #138 assisted resident #016 with care. However, soon after beginning the provision of care, PSW #138 proceeded to ignore resident #016 while they

used an electronic device.

Inspector #679 attempted to speak with resident #016 regarding the incident, however they declined to discuss the incident.

Inspector #679 reviewed a document titled "Investigation Notes re: resident #016", which identified that resident #016 stated every time PSW #138 is assigned to assist them, they "ignore" resident #016.

Inspector #679 reviewed the home's internal investigation file of the allegations towards PSW #138. The details of the allegations towards PSW #138 were documented in a letter, which outlined that PSW #138 received disciplinary action relating to the violation of the Employee Code of Conduct for performing such action during resident care.

Inspector #620 reviewed an undated document titled, “Standards of Conduct.” The document stated that staff were to, “conduct themselves in a positive and cooperative manner and demonstrated respect for residents…”

In an interview with the home's ADOC, they identified that utilizing an electronic device when providing care to a resident would not be considered caring for a resident in a way that treated them with respect and courtesy.

2. Inspector #620 reviewed a CI report submitted to the Director. The CI report described that on a particular day, resident #032, #033, and #034 had reported being yelled at, being told inappropriate comments, and that call bells were cancelled without an inquiry by a staff member to determine the needs of the resident.

Inspector #620 reviewed the home’s investigation of the allegation of verbal abuse/neglect. According to the home’s investigation all three residents described the same staff member. The home had determined that the only staff member fitting the description was PSW #132. PSW #132 was placed off work pending the investigation. On a particular day, the DOC interviewed PSW #132 and determined that PSW #132 did act inappropriately toward resident #032, #033, and #034. The details of PSW #132’s transgression was documented in a letter. The document indicated that PSW #132 was responsible for a policy/procedure violation, performance transgression, and behaviour/conduct infraction. Further review of the letter indicated that PSW #132 agreed that they did respond inappropriately to

resident #032, #033, and #034.

Inspector #620 interviewed the DOC who indicated that PSW #132 had been disrespectful with resident #032, #033, and #034.

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 ensuring that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects the residents dignity, to be implemented voluntarily.

WN #4: 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 :

The Licensee has failed to ensure that any policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During a record review by Inspector #679, resident #001 was identified as having

had a recent weight change.

During a review of the home's electronic record for resident #001, Inspector #679 identified that over the course of a one month period, resident #001 had a significant weight change. Inspector #679 could not locate a re-weigh for resident #001.

In an interview with RPN #113, they identified that it was the home's expectation that if there was a change in a resident's weight of plus or minus 2 kg staff were to complete a re-weigh of the resident. If the re-weigh identified that there had been a weight gain or loss of 2 kg, then a referral was to be sent to the Registered Dietitian. In the same interview, RPN #113 indicated that they could not locate a re-weigh for resident #001, and that the Registered Dietitian would have any copies of re-weighs.

In an interview with Inspector #679, the Director of Care identified that if there was a change in a resident’s weight of plus or minus 2.5 kg, staff were to complete a re-weigh.

A review of the undated resident weight record outlined instructions to staff as follows: “Weights are to be taken approximately 30 days apart. If there is a significant change over the previous month, (+/- 2.5 kg), the resident is to be reweighed within 2 days. The Registered Staff is to be notified immediately”.

In an interview with Inspector #679, the home's Registered Dietitian identified that it was the home's expectation that a re-weigh should have been completed for resident #001, and that this did not occur.

2. Inspector #620 reviewed a critical incident (CI) report submitted to the Director by the licensee. The CI report described that resident #030 had a fall that resulted significant change which required the resident to be admitted to the hospital. The fall resulted in an injury.

Inspector #620 reviewed the resident's clinical record and identified that the resident had experienced a number of falls over a three month period.

Inspector #620 reviewed a document titled, "Falls Prevention and Management Program-RC-06-04-01" last revised in May, 2016. Under the heading of, "Procedures" subheading, "Interdisciplinary Team Prevention of Falls" the

document indicated that staff were to, "Screen all residents on admission, annually, change in condition that could potentially increase the resident's risk for falls/fall injury, or after a serious fall or multiple falls (if not already at high risk). Appendix 2 Scott Fall Risk Screen for Residential Long-Term Care".

A review of the resident's Scott Fall Risk Screen assessments revealed that resident #030 received an assessment on a particular day, with a risk score indicating a specific risk. The resident's next Scott Fall Risk Screen was conducted three months later, with a score indicating a different risk level. Despite the resident experiencing a number of falls over a three month period, no Scott Fall Risk Screen assessments were conducted.

Inspector #620 interviewed the home's RAI/MDS Coordinator who indicated that they reviewed the Scott Fall Risk Screen assessments for resident #030 over a three month period. They stated that the resident had not received the assessment as was required by the home's Fall Prevention Program.

Inspector #620 interviewed the DOC who indicated that resident #030 should have received a Scott Fall Risk Screen assessment when they experienced numerous falls. They noted that assessment was an important component of the home's Fall Prevention Program and that it was used to assess risk.

3. Inspector #679 reviewed a CI report submitted to the Director. The CI report described that resident #001 had a fall that resulted in a significant change which required the resident to be admitted to the hospital. The fall resulted in an injury.

A review of the resident's Scott Fall Risk Screen electronic assessment revealed that resident #001 received an assessment on a particular date, which identified a risk score indicating a specific risk level.

A review of the home's fall policy titled “Fall Prevention and Management Program: Appendix 5 Indicator Flagging Guide-RC-06-04-01" identified that a resident with a score greater than 7 on a Scott Fall Risk Assessment will be flagged. The policy then identified that residents in the Falling program will be identified through the use of: a wrist band or visible clothing item designated by the home, an indicator on the door and near the bed, and a flag on the chart.

During observations, Inspector #679 did not locate the indicator icon on either a wrist band/visible clothing item on the resident, nor on the residents door.

During an interview with the DOC, they verified that any resident identified as being at a specific risk level for falls were to be identified through the home's falling program and have an indicator applied to the resident's door and mobility aid.

4. On May 4, 2017 at 1525 hours, Inspector #613 compared the controlled substance count sheets with the actual controlled substances available on a certain unit in the home, with RN #107 and observed discrepancies for resident #026 and #027. The scheduled controlled substance medications were not signed as being administered at their scheduled times.

For resident #026, the documentation form titled, "Monitored Medication Record for 7-Day Card" identified a controlled substance with prescribed instructions. The balance of medications administered should have identified a specific number of doses remaining; however, the form identified a different number of doses remaining as the balance. There was no documentation to identify that the controlled substance had been administered to resident #026 at a particular time, as ordered by the prescriber.

For resident #027, the documentation form titled, "Monitored Medication Record for 7-Day Card" identified a controlled substance with prescribed instructions. The balance of medication administered should have identified a specific number of doses remaining; however, the form identified a different number of doses remaining. There was no documentation to identify that the controlled substance had been administered to resident #027 at a particular time, as ordered by the prescriber.

RN #107 verified the controlled substances count discrepancies on the documentation forms titled, "Monitored Medication Record for 7-Day Card" for resident #026 and resident #027. RN #107 confirmed that both medications should have been documented as administered by RPN #106 when the medications had been administered.

The Inspector interviewed RPN #106, who confirmed they had administered the medications to both residents as ordered and they were aware that they had not signed for the medications on the Monitored Medication Record for 7-Day Card. RPN #106 stated to the Inspector that it was the home's expectation to document for the medications administered on the Monitored Medication Record for 7-Day Card, immediately after the medication had been administered to each resident.

A review of the medication policy titled, "Narcotics and Controlled Drugs" last revised December 2011, identified that following the administration of the medication, documentation is to be completed on the Medication Administration Record (MAR) and also on the controlled substance counting form as per the pharmacy policy and procedure.

During an interview with the DOC, they confirmed that registered staff were to document in the eMAR on Point Click Care and on the Monitored Medication Record for 7-Day Card form immediately following the administration of narcotics and controlled substances. The DOC confirmed that RPN #106 did not follow the home's policy to document for medications immediately after administration.

On May 5, 2017, the Inspector noted the "Monitored Medication Record for 7-Day Card" for resident #027, had still not been updated to show all the medications that had been administered by RPN #106.

5. Inspector #613 reviewed a CI report that was submitted to the Director on a particular day. The CI report described that RPN #129 completed a controlled substance count alone on a certain date, and noted a discrepancy of two missing controlled substance dosages from resident #025's blister pack card. The CI report identified that the home had conducted an internal investigation and that the police had been notified; however, the controlled substance tablets had not been located.

A review of the home's internal investigation file identified that RPN #129 notified RN #128 of the missing controlled substance in April 2017, after they had completed a narcotic count on their own. RN #128 verified that there were two missing controlled substance dosages from resident #025's blister pack card and the two registered staff were unable to locate the missing controlled substance. The investigation file identified that RPN #130 who had worked the evening shift in April 2017 and RPN #131 who had worked the following night shift, both had not completed a controlled substance count at shift change in April 2017 at 2300 hours. The investigation also noted that RPN #131 had not completed a controlled substance count at shift change with RPN #129 the next day.

A review of the Extendicare policy titled, "Narcotics and Controlled Drugs" last revised December 11, 2017, identified that two staff (one leaving and one coming on duty) must complete a narcotic count together of all narcotics and controlled drugs at the end/beginning of each shift. Additionally, the Medical Pharmacies

policy titled, "Shift Change Monitored Drug Count" last revised February 2017, identified two staff (leaving and arriving) together count the actual quantity of medications remaining, record the date, time, quantity of medication and sign in the appropriate spaces on the "Shift Change Monitored Medication Count" form and confirm the actual quantity was the same as the amount recorded on the "Individual Monitored Medication Record".

During an interview with RPN #129, they verified that RPN #131 had not completed a controlled substance count with them on a certain day.

The Inspector interviewed RPN #106, RPN #116, RPN #129 and, RN #128, who all confirmed that two registered staff were expected to complete a controlled substance count together at each shift change. All registered staff informed the Inspector that the nurse leaving their shift and the nurse arriving for their shift were to count the narcotics and controlled medications together.

Inspector #613 reviewed the form titled, "Shift Change Monitored Medication Count" which identified the discrepancy of the missing controlled substance dosages in April 2017 at 0700 hours. The Inspector noted that there were two initials for signature by staff on two particular days in April 2017.

During an interview with the ADOC, they revealed to the Inspector that RPN #130 and RPN #131 had pre-signed the form titled, "Shift change Monitored Medication Count," but they had not counted the controlled substances together at shift change. The ADOC confirmed that pre-signing the form and not counting the controlled substances together was against the home's policy.

During an interview with the DOC, they confirmed that RPN #130 and RPN #131 had not followed the home's Extendicare and Medical Pharmacies policies. Additionally, the registered staff had admitted they had not completed the controlled substance count at shift change. The DOC confirmed RPN #130 had not completed the controlled substance count at shift change in April 2017, and that RPN #131 had not completed the controlled substance count at shift change on two days in April 2017.

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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically the Narcotics and Controlled drug policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

a) During the initial tour of the home, Inspector #613 observed a used and unlabelled container of body lotion in a unit's tub room. In another unit's tub room one black comb as well as one emery board were noted used and unlabelled. On a unit, two used and unlabelled deodorants were noted, while in a unit's tub room one used and unlabelled body wash was noted.

During an interview with PSW #105, they verified to Inspector #613 that the personal items found in a unit's tub room, including: one used and unlabelled deodorant and one used and unlabelled container of ointment were to be labelled.

In five of the home's eight tub rooms, 63 per cent had used, unlabelled resident personal items.

b) Inspector #679 observed one used, unlabelled bottle of mouthwash, one used, unlabelled bottle of body wash and a soiled unlabelled urinal in resident #001's shared bathroom. In resident #020's shared bathroom, two used, unlabelled bottles of body lotion were observed.

Inspector #609 observed a used, unlabelled toothpaste tube, two used, unlabelled toothbrushes, two unlabelled combs with skin debris noted on them and a used, unlabelled deodorant in resident #024's shared bathroom. In resident #021's shared bathroom an electric razor, comb, deodorant, brush with hair on it, and one toothpaste tube were noted used and unlabelled.

A review of the home's procedure titled "Extendicare Maple View Admission Checklist" last revised May 2015, indicated that within 48 hours of admission residents' personal items were to be labelled.

During an interview with the DOC, they verified that residents' personal items should have been labelled within 48 hours of admission and of acquiring in the case of new items. [s. 37. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required and was dressed appropriately, suitable to the time of day in keeping with their preferences, in their own clean clothing and appropriate footwear.

During an observation on a particular day at 1500 hours, Inspector #613 observed resident #003 dressed in night clothes. Additionally, the Inspector observed that on two other days in May 2017, resident #003 was dressed in night clothes during the day.

A review of resident #003's care plan did not identify that the resident preferred to wear night clothes during the day.

During interviews with PSW #126 and RPN #119, they verified that residents should not be wearing their night clothes during the day unless their preference was identified in their care plan. PSW #126 confirmed that staff sometimes dressed resident #003 in their night clothes as they were sometimes resistive and difficult to dress. PSW #126 confirmed that resident #003's care plan did not identify that wearing night clothes was resident #003's preference.

During an interview with the Administrator and DOC, they confirmed that residents should not be in their night clothes during the day unless it was their preference and identified in their care plan. [S. 40.]

2. A CI report submitted to the Director alleged that PSW #121 would not let resident #017 wear their choice of night wear to bed.

In an interview with resident #017, they indicated to Inspector #679 that they were upset that PSW #121 would not allow them to wear their choice of night wear to bed.

A review of the home's internal investigation notes, outlined that PSW #121 admitted to asking evening staff not to dress the resident in their choice of night wear as it was too difficult.

In an interview with the homes ADOC, they confirmed that not allowing a resident to wear their choice of night wear as requested was failing to ensure that the residents right to be clothed in a manner consistent with the resident's needs was met. [s. 40.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary, and that a written record was kept of everything required under clauses (a) and (b).

During an interview with the DOC, they informed Inspector #613 that when medications incidents occurred, the registered staff completed a medication incident report on-line, which was reported directly to the Pharmacy service provider. The DOC informed the Inspector that they did not have copies of each medication incident at the home, rather they received forms from the Pharmacy, identifying the description summary of each medication incident that had been reported.

A review of the forms titled, "MEDe Report – Medication Incidents for February 2017 and April 2017," identified categories as follows: a number to identify the resident (no name), the report date, a description of incident, stages involved, severity outcome, precipitating event category, if pharmacy had investigated and

status of the report. Both the February 2017, and April 2017 forms identified five medication errors for each month, a total of 10 medication errors for 2017. There was no information or written record to identify that the home had reviewed, analyzed and taken corrective action for all medication incidents. There were no medication errors for January 2017 and March 2017.

During an interview on May 4, 2017, with the DOC, they informed the Inspector that corrective actions were done by the ADOC, DOC or registered nursing staff, depending on the severity of the medication error and that the corrective actions should be documented in the resident's progress notes on Point Click Care.

On May 5, 2017, the DOC requested all medication incident reports from Pharmacy dating January, 2017 to March 2017, as requested by the Inspector to determine the resident's names, that all medication incidents were documented and analyzed, corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b). The Pharmacy provided five of the ten incident reports that were identified on the forms titled, "MEDe Report – Medication Incidents for February 2017 and April 2017". The Inspector reviewed the five medication incident reports that were provided and identified that only three identified documentation to support that each medication incident was analyzed and that corrective actions were taken to prevent recurrence.

A review of the progress notes for each resident acknowledged on the medication incident reports, identified no corrective actions that were taken to prevent recurrence of the incidents.

A review of the home's policy titled, "Medication Incidents" last revised September 2010, identified that the DOC or designate was to review all documentation received and initiate an investigation into the incident. If required, an action plan would be developed to address the outcome of the investigation. Action plans were to include an evaluation component to minimize the risk of the incident occurring again. As well, Medical Pharmacies policy titled, "Medication Incident Reporting" last revised on February 2017, identified that the Medication Incident Report was reviewed, analyzed and included in the evaluation at the home in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview with the DOC, they confirmed that an analysis of all medication incidents had not been documented. The DOC was unable to provide a written documentation to the Inspector to identify that corrective actions were taken

immediately for all medication errors. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home, since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, that any changes and improvements identified in the review were implemented, and that a written record was kept of everything provided in clause a and b.

Inspector #613 interviewed the DOC, who stated that medication incidents were discussed at the quarterly Professional Advisory Committee (PAC) meetings. The DOC provided the Inspector with the Clinical Consultant Pharmacist Quarterly Reports dated February 28, 2017 and November 22, 2016.

A review of the Clinical Consultant Pharmacist Quarterly Reports dated February 28, 2017 and November 22, 2016, failed to reveal any analysis related to preventing medication incidents or any changes and improvements made in the review.

A review of the home's policy titled, "Medication Incidents" last revised September 2010, identified that the home's Professional Advisory Committee was to review all medication incident reports, looking for trends in the home or with the pharmacy. As well, Medical Pharmacies policy titled, "Medication Incident Reporting" last revised February 2017, identified that all medication incidents were reviewed by the homes "interdisciplinary team" including the Administrator, Director of Care, the Medical Director or prescriber, and the Clinical Consultant Pharmacist. Changes and improvements identified in the review were to be implemented and a written record kept on file at the home.

On May 9, 2017, Inspector #613 interviewed the DOC, who stated that they did not have a record to show the Inspector that all medication incidents and adverse drug reactions were reviewed and analyzed quarterly in order to reduce and prevent medication incidents and adverse drug reactions. The DOC confirmed that quarterly reviews of all medication incidents and adverse drug reactions had not been done and there was no written documentation of the changes and improvements implemented. [s. 135. (3)]

WN #8: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

On May 1, 2017, Inspector #609 observed the dinner meal service on a home area. During the meal service RPN #100 was observed providing residents with their entrées from the servery, removing dirty dishes from tables and assisting other residents to feed, all without performing hand hygiene between tasks.

A review of the home's policy titled "Hand Hygiene- IC-02-01-07" last updated September 2016, indicated that hand hygiene was required before and after handling or serving food as well as before and after assisting a resident with feeding.

During an interview with RPN #100 on May 1, 2017, they verified that they did not perform hand hygiene between providing meals to residents, assisting with feeding and removing dirty dishes to the soiled bin. RPN #100 verified that they should have performed hand hygiene between these tasks.

During an interview with the Food Services Manager (FSM) they verified that RPN #100 should have performed hand hygiene between providing meals, assisting with

feeding and removing dirty dishes. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift symptoms were recorded and that immediate action was taken as required

Inspector #542 completed a review of resident #009's health care record as they were identified as having a prevalence of illness. Inspector #542 noted that it was documented in the progress notes for resident #009 that they were exhibiting symptoms over a one month period.

On May 4, 2017, Inspector #542 interviewed the Assistant Director of Care (ADOC) who was the home's Infection Prevention and Control (IPAC) lead. They indicated that when a resident started to exhibit signs of an illness, then the Registered Practical Nurse on the unit will document in the progress notes and place the resident on the home's "Daily 24-Hour Symptom Surveillance Form". At the end of the 24 hours, the document is then provided to the IPAC lead.

Inspector #542, reviewed the home's Daily 24-Hour Symptom Surveillance Form over a one month period. The Inspector was unable to locate any tracking for resident #009. Subsequently, the Inspector spoke with the IPAC lead who was also unable to locate any information related to resident #009 on the form.

Inspector reviewed the home's policy titled, "Infection Surveillance and Control, IC-03-01-01", updated September 2016. The policy indicated that the staff were to record on the Daily 24-Hour Symptom Surveillance form any symptoms that may determine an infection and/or the possible presence of a communicable disease outbreak. [s. 229. (5) (b)]

Issued on this 10 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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) : MICHELLE BERARDI (679) - (A1)

Inspection No. / No de l'inspection : 2017_655679_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 007599-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 10, 2017;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue, SAULT STE. MARIE, ON,
P6B-4J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Carly Brown

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 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 ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with; specifically ensure that incidences of abuse or neglect are reported by the witness immediately, as outlined in the home's policy.

Grounds / Motifs :

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

A CI report submitted to the Director, outlined an alleged incident of staff to resident verbal abuse. The CI report outlined that PSW #139 entered resident #029's room and witnessed PSW #140 yelling at resident #029.

Inspector #642 reviewed the home's internal investigation notes, and found written documentation, which outlined that PSW #139 confirmed that they had not informed the RN/Supervisor in charge at the time of the alleged verbal abuse.

During an interview with Inspector #642, PSW #139 indicated that they had witnessed the incident of alleged abuse between PSW #140 and resident #029, however, did not report the incident until the next day.

Inspector #642 conducted an interview with the DOC, who indicated that it was the expectation of the home that all suspected incidents of abuse should be reported immediately to the designate in order to initiate the appropriate investigations and protect the residents from harm. (642)

2. A CI report submitted to the Director, alleged that resident #015 was found sitting in the common area of their home unit when RPN #136 arrived on a particular day. When RPN #136 questioned PSW #120 about resident #015, PSW #120 indicated that they had not assisted the resident for the duration of their shift.

a) In a review of resident #015's progress notes written by RPN #136, Inspector #679 identified that resident #015 was received on a particular day, incontinent of urine with altered skin integrity.

Inspector #679 reviewed a letter submitted to the DOC by PSW #137, which indicated that resident #015 was found in a saturated incontinence product, with altered skin integrity.

A review of the internal investigation notes indicated that PSW #120 received a written warning for not providing care for resident #015, leaving the resident unassisted with altered skin integrity.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02" last revised April 2016, identified that "All staff must protect the rights of each resident entrusted in their care".

During an interview with the home's Assistant Director of Care (ADOC), they indicated that the neglect of resident #015 by PSW #120 was substantiated through the home's investigation.

b) A review of the CI report indicated that the incident of neglect was reported to the Director one day after the incident occurred.

In an interview with the home's ADOC, they indicated that the registered staff member did not immediately report the allegations of neglect towards resident #015, as specified in the home's policy, but rather waited until the following day. (679)

3. A Critical Incident (CI) report was submitted to the Director, alleging staff to resident physical abuse. The CI report indicated that on a particular day, PSW #110 had performed a forceful action to the resident as reported by PSW #111. According to the CI report, PSW #111 reported the allegation of abuse to RPN #146 the following day.

Inspector #542 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02", updated April 2016. The policy indicated that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

In an interview with Inspector #542, PSW #124 indicated that staff were to report any allegations of suspected or witnessed abuse to their supervisor.

Inspector #542 interviewed the DOC, who acknowledged that PSW #111 did not report the alleged abuse immediately and that they reported it one day later.

The decision to issue this compliance order was based on the scope which was determined to be a pattern, the severity, which was determined to be actual harm or risk, and the compliance history, which despite previous non-compliance issued, including one compliance order, issued during inspection #2016_562620_0029, and a voluntary plan of correction (VPC) issued during inspections #2016_395613_0014, #2016_395613_0007 and #2015_281542_0005, non-compliance continued with this section of the legislation.
(542)

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

Aug 17, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_562620_0030, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall:

a) Ensure that the care set out in the plan of care is provided to the resident as specified in the plan, in respect to fall prevention interventions.

b) Conduct a review of all residents who are at a specific risk for falls to ensure that the fall prevention interventions are being implemented as outlined in the plan of care, and keep a written record of the review.

Grounds / Motifs :

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 Compliance Order (CO) #002 was issued to the home on February 27, 2017, related to the licensee's failure to comply with s. 6. (7) of the LTCHA, 2007, c. 8 during critical incident inspection #2016_562620_0030 (A1).

The CO required the licensee to review all care plans for residents who were identified as being at a specific level of risk for falls, to ensure they were receiving care as specified within their plans of care, and that the residents' plans of care

accurately reflected their assessed needs.

Full compliance with the CO was expected by March 31, 2017.

a) A Critical Incident (CI) report was submitted to the Director indicating that resident #035 fell and was transferred to the hospital with an injury.

Inspector #609 reviewed resident #035's last two fall risk assessments and found that the resident was at a risk for falls.

Since the fall with accompanying injury on a particular day, resident #035 had a number of additional falls.

A review of resident #035's current plan of care indicated fall prevention interventions, related to the use of a mobility aid and required care to mitigate the risk of falls.

The Inspector observed resident #035 sitting in the unit's common area. The resident did not have their mobility aid near them. In the resident's room a mobility aid was noted. The Inspector also observed that the resident was assisted to the dining room for lunch by PSW #145, without the use of a mobility aid.

During an interview with PSW #145, they indicated that resident #035 was to receive specific care. PSW #145 verified that the resident did not receive the care.

Further observations of resident #035 found the resident in bed, with the bed not set up in the manner that was indicated in the resident's plan of care to mitigate falls.

During an interview with the DOC, they verified that care as specified in the plan was to be provided to the resident, and that this did not occur with resident #035 as it related to interventions for specific care, to mitigate fall risk/injury and the use of the resident's mobility aids.

b) On a certain date, resident's #027, #035 and, #037 were noted by Inspector #609 to have an indicator outside of their room.

A review of all three residents' last fall risk assessment indicated they were at a specific level of risk for falls.

A review of the home's memorandum to all nursing staff dated November 2016, indicated that residents identified in the falls program were to have an indicator applied to their doors as well as their mobility or gait aid.

Further observations of the three residents' bedrooms found no indicator applied to their mobility aid.

During an interview with the DOC, they verified that any resident identified as being at a certain risk for falls were to be identified through the home's program and have a identifier applied to the resident's door and mobility aid. (609)

2. Inspector #679 reviewed a CI report submitted to the Director. The CI report described that resident #001 had a fall on a particular day, that resulted in a significant change which required the resident to be admitted to the hospital. The fall resulted in an injury. The CI report further indicated that resident #001 fell again the day that they returned from the hospital.

A review of the current electronic care plan, identified that resident #001 was to have a particular fall prevention device applied to their bed and a fall prevention device applied to their mobility aid, to alert staff if resident #001 was attempting to self-transfer.

During an observation of the resident, Inspector #679 noted the resident asleep in bed, with no fall prevention devices in place.

In an interview with RPN #144, they confirmed that resident #001 did not have either of the fall prevention devices in place and that there should have been one applied as outlined in their care plan.

The decision to re-issue this compliance order was based on the scope which was determined to be a pattern, the severity which indicated actual harm or risk of actual harm, and the compliance history, which despite previous non-compliance issued including a compliance order issued during inspections #2016_562620_0030 and #2016_395613_0013, non-compliance continued with this section of the legislation. (679)

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

Oct 04, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

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 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 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE BERARDI - (A1)

Service Area Office /
Bureau régional de services : Sudbury