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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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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 #/ No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2018;	2017_616542_0020 (A3)	020164-17, 020165-17	Follow up

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

SHELLEY MURPHY (684) - (A3)

Amended Inspection Summary/Résumé de l’inspection modifié

Extended compliance due date for CO #001 from March 2, 2018 to April 6, 2018.

Issued on this 12 day of February 2018 (A3)

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

Original report signed by the inspector.

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

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

SHELLEY MURPHY (684) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 30 - November 9, 2017.

The following intakes were completed during this inspection:

Two Follow Up intakes related to Compliance Order (CO) #001 issued during inspection #2017_655679_0004 regarding the home's written policy to promote zero tolerance of abuse and neglect of residents and plan of care.

A Critical Incident (CI) inspection, inspection #2017_616542_0019 and a Complaint Inspection, inspection #2017_616542_0018 were completed concurrently with this inspection. As a result, findings of non-compliance related to LTCHA, 2007, s. 6. (7) and s. 20 (1) identified during the Critical Incident inspection and Complaint inspection will be issued in this Follow Up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Acting Assistant Director of Care, Assistant Director of Care, Dietary Manager, scheduling staff, 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, employee files, staffing assignments and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)
0 VPC(s)
2 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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

(A1)
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 previous Compliance Order (CO) was issued during inspection #2017_655679_0004 with a compliance date of August 17, 2017. The CO

indicated that 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 high 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".

1) A Critical Incident (CI) report was submitted to the Director on a specific day in October, 2017, for an incident that occurred on a previous day. It was documented in the CI report that resident #040 had a fall which resulted in a fracture.

On November 9, 2017, Inspector #542 reviewed resident #040's health care record. It was documented in the progress notes that resident #040 returned from the hospital on a specific day in October, 2017, and had a fall from their bed. No injuries were sustained. Inspector #542 reviewed the current care plan and noted that the following fall intervention was documented; resident #040 was to have a specific intervention initiated while seated to alert the staff if they were attempting to stand.

Inspector #542 observed resident #040 in their bathroom. The resident was sitting partially on their chair, without the specific intervention applied. Inspector #542 approached the Registered Practical Nurse (RPN) who was outside of the resident's room. RPN #147 entered the resident's room and provided assistance to the resident. They also implemented the specific intervention. Inspector #542 asked RPN #147 if resident #040 was to have the intervention applied at all times when they were in their chair. RPN #147 indicated, yes and that they were unsure as to why the resident had not had the intervention applied.

Inspector #542 interviewed PSW #110 on this same day. PSW #110 verified that they were assigned to resident #040 and provided them with morning care. Inspector #542 asked if the resident was to have the specific intervention applied when in their chair, PSW #110 indicated that they were to the intervention applied.

2) Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director. The CI report indicated that PSW #118 provided an improper transfer to resident #010, which resulted in the resident falling and sustaining an injury. The

CI report indicated that, PSW #118 positioned the resident at the side of their bed in preparation for the specific transfer. The PSW then left resident #010 unattended while they went to the door to find another staff member to assist them. As a result, resident #010 fell off of the bed and onto the floor.

Further review of the CI report, indicated that PSW #118 left resident #010's room to get PSW #117. Both PSWs then transferred resident #010 back into bed without the use of a mechanical lift. The PSWs did not report the resident's fall or their actions immediately to the registered staff. PSW #117 reported resident #010's fall approximately one and a half hours later to RPN #116.

A review of resident #010's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) at time of the fall, identified that the resident required two persons physical assistance and the use of a mechanical lift.

A review of resident #010's care plan identified that the resident was no longer able to use the specific mechanical lift for transfers and required an alternative mechanical lift for all transfers, using two staff members.

During an interview on November 1, 2017, with PSW #118, they indicated they had not reviewed resident #010's care plan prior to providing care. PSW #118 verified they had not followed the resident's care plan for transferring with the use of the lift.

During an interview on the same date with PSW #117, they indicated that they knew resident #010's care plan identified a lift for all transfers and verified that they had not followed the resident's care plan for transferring with the use of the lift.

During an interview with the Acting Director of Care (Acting DOC), they verified that PSW #118 had admitted to not reviewing resident #010's care plan prior to providing care and confirmed that both PSW #118 and PSW #117 had not followed resident #010's plan of care; as a result, the resident sustained an injury.

3) Inspector #642 reviewed two complaints that were submitted to the Director, one in September, 2017, and the other in October, 2017, outlining concerns related to the care plan not being followed for resident #005.

Inspector #642 reviewed resident #005's health care records and the current care plan dated October, 2017, and noted, under the focus heading for dressing was a specific intervention that detailed how to dress resident #005 for breakfast on their

bath days. The care plan also indicated another specific intervention on how the resident was to be toileted before getting dressed for the day and how the staff were to transfer resident #005.

Inspector #642 interviewed the complainant on October 27, 2017, who verified that they had placed a video camera in resident #005's room and had provided the Long-Term Care (LTC) home with the video recordings.

Inspector #642 reviewed the one minute video recordings that the LTC home had for the specific dates in question; under the video recording dated for a morning in September, 2017, PSW #106 had entered resident #005's room on the resident's bath day. Resident #005 requested to be dressed as per their care plan intervention, which was not provided. PSW #106 then placed the resident in the transfer sling for the transfer, then left the room. PSW #130 then proceeded into resident #005's room and the resident then asked PSW #130 for the specific dressing intervention. PSW #130 indicated that resident #005 would be okay without it and did not provide the intervention to them. PSW #130 then proceeded to transfer resident #005 out of bed with the specific transferring intervention as per resident #005's plan of care. When PSW #106 came back to assist, they asked why the resident was crying and PSW #130 indicated, because they had not provided the specific dressing intervention to resident #005.

Inspector #642 reviewed the LTC home's video recording, dated for a day in September, 2017. During resident #005's morning care, they requested a specific toileting intervention from PSW #133, who indicated that they were going to provide a different toileting intervention. PSW #133 then proceeded to transfer resident #005 into a sitting position and then placed the resident on the mechanical lift without another staff members assistance and then proceeded to provide the resident with a toileting intervention that resident #005 did not want. PSW #133 then completed this intervention and placed resident #005 into their wheelchair using a mechanical lift without another staff members assistance. PSW #133 then stated to resident, "stop whining, I will do what you want, but don't whine."

Inspector #642 reviewed the home's policy titled, "Care Planning, RC-05-01-01, last updated April 2017," under the procedure, it stated, "ensure that staff understand and comply with the care planning policy. The care plan will be reflective of the resident's goals and preferences through collaboration with the resident/SDM. As the resident's status changes, members of the interdisciplinary team are to update the plan of care so that at any point in time, the care plan

continues to be reflective of the current needs and preferences of the resident.”

Inspector #642 interviewed PSW #130, on November 2, 2017, and PSW #131 and RN #128 on November 3, 2017, they all indicated that it is was a requirement that the staff follow what the resident care plan as indicated.

The Inspector interviewed the Acting Director of Care (ADOC) and the Administrator on November 3, 2017, who all indicated that it was a requirement that staff provided the care that was in the resident’s care plan and after reviewing the video recordings, staff had not provided the care set out in the plan of care to resident #005 as specified in the plan.

Additional Required Actions: DR #001, the above written notification is also being referred to the Director for further action by the Director. [s. 6. (7)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 001

WN #2: 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

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

A previous Compliance Order (CO) was issued during inspection # 2017_655679_0004, with a compliance date of August 17, 2017. The CO indicated that the licensee was to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with; specifically, ensure that incidences of abuse or neglect were reported by the witness immediately, as outlined in the home's policy.

1) A Critical Incident System (CI) Report was submitted to the Director on a specific day in March, 2017, regarding an allegation of staff to resident verbal abuse. The CI report indicated that PSW #107 advised resident #013 not to ring their call bell for assistance, which resulted in resident #013 experiencing a specific indignity.

Inspector #681 reviewed the home’s policy titled “Zero Tolerance of Resident Abuse and Neglect Program” last updated April 2017, which indicated that all residents were to be treated with dignity and respect and were to be protected from all forms of abuse and neglect at all times.

Inspector #681 reviewed the home’s investigation notes related to the incident. The home’s investigation notes included an interview with resident #013, which indicated that PSW #107 said to resident #013 “why are you ringing the bell, I am coming don’t you know?” The home’s investigation notes indicated that resident #013 did not appreciate PSW #107’s tone of voice and left them fearful to ring for assistance when PSW #107 was working on the unit.

During an interview with Inspector #681, resident #013 indicated that PSW #107 was very rude to them and said "you don’t have to press two bells – remember that

next time". Resident #013 also stated that PSW #107 had said that they did not want to provide them with a specific type of assistance.

Inspector #681 reviewed the employee file for PSW #107, which indicated that PSW #107 received disciplinary action related to the incident because, through the home's investigation, it was determined that PSW #107 was verbally and emotionally abusive towards resident #013.

In an interview with Inspector #681 on November 2, 2017, Acting DOC #103 indicated that they were not familiar with the incident because they were not employed at the home when the incident occurred. However, based on the discipline that was provided, it was likely that resident abuse had occurred.

2) The licensee had submitted two Critical Incident (CI) reports, on two specific days in October, 2017, which alleged staff to resident verbal abuse.

Inspector #642 reviewed the LTC home's video recording, dated for a specific day in September, 2017. During resident #005's morning care, they requested a specific toileting intervention from PSW #133, who indicated that they were going to provide a different toileting intervention. PSW #133 then completed the toileting intervention and placed resident #005 into their chair. PSW #133 then stated to resident, "Stop whining, I will do what you want, but don't whine."

The Inspector had reviewed the licensee's investigation documentation titled "Extendicare Discipline Notice" and noted that PSW #133 had received discipline.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect" dated April 2017. The policy indicated that the home had a zero tolerance of any form of abuse or neglect by any person. The policy defined verbal abuse as, "any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident." [s. 20. (1)]

Additional Required Actions:

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

Issued on this 12 day of February 2018 (A3)

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

Original report signed by the inspector.

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHELLEY MURPHY (684) - (A3)
Inspection No. / No de l'inspection :	2017_616542_0020 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020164-17, 020165-17 (A3)
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 12, 2018;(A3)
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

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_655679_0004, 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 is required to prepare, submit and implement a plan for achieving compliance under s.6 (7) of the LTCHA. This plan shall include:

a) a detailed description of the steps that the licensee will take to ensure that the care set out in the plan of care for residents is provided as specified in their plan.

b) a review of all resident care plans to ensure that the staff are following the care set out in the plan with regards to but not limited to, fall prevention interventions and transferring requirements.

c) a process that is developed and implemented to ensure that resident care is provided to the residents as specified in the plan. The process is to include an auditing mechanism that identifies when care is not being provided as specified, who is required to undertake the audit, and at which frequency the audits are to occur.

This plan may be submitted in writing to Long-Term Care Homes Inspector, Jennifer Lauricella at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133. The plan shall be submitted by January 26, 2018.

Grounds / Motifs :

(A1)
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 previous Compliance Order (CO) was issued during inspection #2017_655679_0004 with a compliance date of August 17, 2017. The CO indicated that 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 high 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".

1) A Critical Incident (CI) report was submitted to the Director on October 2, 2017, for an incident that occurred on October 1, 2017. It was documented in the CI report that resident #040 had a fall which resulted in a fractured left hip requiring surgical repair.

On November 9, 2017, Inspector #542 reviewed resident #040's health care record. It was documented in the progress notes that resident #040 returned from the hospital on October 5, 2017, and had a fall from their bed. No injuries were sustained. Inspector #542 reviewed the current care plan and noted that the following fall intervention was documented; resident #040 was to have a seat belt alarm applied to their wheel chair to alert the staff if they were attempting to stand from their wheel chair.

On November 9, 2017, Inspector #542 observed resident #040 in their bathroom at 1125 hours (hrs). The resident was sitting partially on their wheel chair, with their pants around their ankles and the seat belt alarm was not fastened around the resident. No sound was coming from the unfastened alarm seat belt. Inspector #542 approached the Registered Practical Nurse (RPN) who was outside of the resident's room. RPN #147 entered the resident's room and provided assistance to the resident. They also fastened the alarm seat belt on the resident and at that time the alarm sounded on the seat belt. Inspector #542 asked RPN #147 if resident #040 was to wear the alarm belt at all times when they were in their wheel chair. RPN #147 indicated, yes and that they were unsure as to why the resident had not had it on.

Inspector #542 interviewed PSW #110 on this same day. PSW #110 verified that they were assigned to resident #040 and provided them with morning care. Inspector #542 asked if the resident was to have their seat belt alarm on when in their wheel chair, PSW #110 indicated that they were to have it on.

2) Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director. The CI report indicated that PSW #118 provided an improper transfer to resident #010, which resulted in the resident falling and sustaining an injury. The CI report indicated that, PSW #118 positioned the resident at the side of their bed in preparation for a sit/stand lift transfer. The PSW then left resident #010 sitting on the side of the bed unattended while they went to the door to find another staff member to assist them. As a result, resident #010 fell off of the bed and onto the floor.

Further review of the CI report, indicated that PSW #118 left resident #010's room to get PSW #117. Both PSWs then transferred resident #010 back into bed without the use of a mechanical lift. The PSWs did not report the resident's fall or their actions immediately to the registered staff. PSW #117 reported resident #010's fall approximately one and a half hours later to RPN #116.

A review of resident #010's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) at time of the fall, identified that the resident required extensive assistance with two persons physical assistance and the use of a mechanical lift.

A review of resident #010's care plan identified that the resident was no longer able to use a sit to stand lift safely, and required the overhead lift for all transfers, using two staff members.

During an interview on November 1, 2017, with PSW #118, they indicated they had not reviewed resident #010's care plan prior to providing care. PSW #118 verified they had not followed the resident's care plan for transferring with the use of the overhead lift.

During an interview on the same date with PSW #117, they indicated that they knew resident #010's care plan identified an overhead lift for all transfers and verified that they had not followed the resident's care plan for transferring with the use of the overhead lift.

During an interview with the Acting Director of Care (Acting DOC), they verified that PSW #118 had admitted to not reviewing resident #010's care plan prior to providing care and confirmed that both PSW #118 and PSW #117 had not followed resident #010's plan of care; as a result, the resident sustained an injury.

3) Inspector #642 reviewed two complaints that were submitted to the Director on September 12, 2017, and October 26, 2017, outlining concerns related to the care plan not being followed for resident #005.

Inspector #642 reviewed resident #005's health care records and the current care plan dated October 31, 2017, and noted, under the focus heading for dressing was an intervention that stated, "dress resident #005 in their housecoat before coming for breakfast on bath mornings." The care plan also stated under the toilet use heading, an intervention, "toilet resident #005 via bed pan 5-10 minutes before getting dressed

for the day.” Under the focus heading transfer, in the care plan, it was documented, “requiring assistance X 2 staff via sit to stand or overhead lift for transfers.”

Inspector #642 interviewed the complainant on October 27, 2017, who verified that they had placed a video camera in resident #005’s room and had provided the Long Term Care (LTC) home with the video recordings.

Inspector #642 reviewed the one minute video recordings that the LTC home had for the specific dates in question; under the video recording dated for the morning of September 20, 2017, PSW #106 had entered resident #005’s room on the resident’s bath day. Resident #005 requested their housecoat, which was not provided. PSW #106 then placed the resident in the transfer sling for the transfer, then left the room. PSW #130 then proceeded into resident #005’s room and the resident then asked PSW #130 for their housecoat. PSW #130 responded, “PSW #106 forgot to put your house coat on, it is not cold anyway and you will be okay without it,” and had not provided resident #005 with their housecoat. PSW #130 then proceeded to transfer resident #005 out of bed with the overhead lift and placed them in their wheelchair, without the assistance of another staff member. When PSW #106 came back to assist, they asked why the resident was crying and PSW #130 said “cause we forgot to put on their housecoat” and then told the resident, “we can’t put on your housecoat because you are already in your wheelchair,” and then placed their housecoat over their legs and brought them out of their room for breakfast.

Inspector #642 reviewed the LTC home’s video recording, dated September 27, 2017. During resident #005’s morning care, they requested the bed pan from PSW #133, who stated, “I will put you on the toilet.” PSW #133 then proceeded to transfer resident #005 into a sitting position and then placed the resident on the sit to stand lift without another staff members assistance and then proceeded to bring the resident into the bathroom while the resident was requesting the bedpan. PSW #133 then brought resident #005 out of the bathroom and placed them into their wheelchair using the sit to stand lift without another staff members assistance. PSW #133 then stated to resident, “stop whining, I will do what you want, but don’t whine.”

Inspector #642 reviewed the home’s policy titled, “Care Planning, RC-05-01-01, last updated April 2017,” under the procedure, it stated, “ensure that staff understand and comply with the care planning policy. The care plan will be reflective of the resident’s goals and preferences through collaboration with the resident/SDM. As the resident’s status changes, members of the interdisciplinary team are to update the plan of care

so that at any point in time, the care plan continues to be reflective of the current needs and preferences of the resident."

Inspector #642 interviewed PSW #130, on November 2, 2017, and PSW #131 and RN #128 on November 3, 2017, they all indicated that it is was a requirement that the staff follow what the resident care plan indicated.

The Inspector interviewed the Acting Director of Care (ADOC) and the Administrator on November 3, 2017, who all indicated that it was a requirement that staff provided the care that was in the resident's care plan and after reviewing the video recordings, staff had not provided the care set out in the plan of care to resident #005 as specified in the plan.

The decision to re-issue this compliance order and Director's Referral was based on the compliance history. A Director's Referral (DR) was previously issued on August 10, 2017, during inspection # 2017_655679_0004. A Written Notification was issued May 10, 2017, during inspection #2017_572627_0005 and two Compliance Orders (CO) issued, one issued on February 27, 2017, during inspection #2016_562620_0030 and the other issued on October 5, 2016 during inspection #2016_395613_0013. The scope, which was determined to be a pattern of residents affected, and the severity, which was determined to be actual harm or risk of actual harm. (542)

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

Apr 06, 2018(A3)

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_655679_0004, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

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

A previous Compliance Order (CO) was issued during inspection # 2017_655679_0004, with a compliance date of August 17, 2017. The CO indicated that the licensee was to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with; specifically, ensure that incidences of abuse or neglect were reported by the witness immediately, as outlined in the home's policy.

1) A Critical Incident System (CI) Report was submitted to the Director on a specific day in March, 2017, regarding an allegation of staff to resident verbal abuse. The CI report indicated that PSW #107 advised resident #013 not to ring their call bell for assistance, which resulted in resident #013 experiencing a specific indignity.

Inspector #681 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program" last updated April 2017, which indicated that all residents were to be treated with dignity and respect and were to be protected from all forms of abuse and neglect at all times.

Inspector #681 reviewed the home's investigation notes related to the incident. The home's investigation notes included an interview with resident #013, which indicated that PSW #107 said to resident #013 "why are you ringing the bell, I am coming don't you know?" The home's investigation notes indicated that resident #013 did not appreciate PSW #107's tone of voice and left them fearful to ring for assistance when PSW #107 was working on the unit.

During an interview with Inspector #681, resident #013 indicated that PSW #107 was very rude to them and said "you don't have to press two bells – remember that next time". Resident #013 also stated that PSW #107 had said that they did not want to provide them with a specific type of assistance.

Inspector #681 reviewed the employee file for PSW #107, which indicated that PSW #107 received disciplinary action related to the incident because, through the home's investigation, it was determined that PSW #107 was verbally and emotionally abusive towards resident #013.

In an interview with Inspector #681 on November 2, 2017, Acting DOC #103 indicated that they were not familiar with the incident because they were not employed at the home when the incident occurred. However, based on the discipline that was provided, it was likely that resident abuse had occurred.

2) The licensee had submitted two Critical Incident (CI) reports, on two specific days in October, 2017, which alleged staff to resident verbal abuse.

Inspector #642 reviewed the LTC home's video recording, dated for a specific day in September, 2017. During resident #005's morning care, they requested a specific toileting intervention from PSW #133, who indicated that they were going to provide a different toileting intervention. PSW #133 then completed the toileting intervention and placed resident #005 into their chair. PSW #133 then stated to resident, "Stop whining, I will do what you want, but don't whine."

The Inspector had reviewed the licensee's investigation documentation titled

"Extendicare Discipline Notice" and noted that PSW #133 had received discipline.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect" dated April 2017. The policy indicated that the home had a zero tolerance of any form of abuse or neglect by any person. The policy defined verbal abuse as, "any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident."

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 two compliance orders, issued during inspection #2017_655679_0004 and #2016_562620_0029, and a voluntary plan of correction (VPC) issued during inspections #2016_395613_0014, #2016_395613_0007 and #2015_281542_0005, noncompliance 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 :

Feb 02, 2018

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 12 day of February 2018 (A3)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SHELLEY MURPHY - (A3)

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

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Service Area Office / Bureau régional de services : Sudbury