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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2019	2019_633577_0006	025461-18, 025748-18, 026649-18, 026807-18, 027738-18, 028363-18, 028761-18, 001272-19, 001998-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

DEBBIE WARPULA (577), CHAD CAMPS (609), LAUREN TENHUNEN (196), SHARON GOERTZEN (742), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 4-8, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
- Four intakes related to staff to resident abuse,

- Four intakes related to resident falls; and

- One intake related to resident to resident abuse.

A Complaint inspection #2019_633577_0005 and a Follow Up inspection #2019_633577_0007 were conducted concurrently with this CIS inspection

During the course of the inspection, the inspector(s) spoke with the Regional Director for Extendicare, Administrator, Senior Director of Care (DOC), Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) coder 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, reviewed home's internal investigation notes, reviewed staff training records, reviewed employee's files as well as reviewed licensee policies, procedures and programs.

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

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

4 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was received by the Director concerning resident #002's unwitnessed fall which resulted in a significant change in the resident's health status.

Inspector #742 reviewed resident #002's care plan, last revised January 28, 2019, which indicated that resident #002 was to have a special apparatus when the resident was in bed.

During observations on three consecutive days, Inspector #742 observed the resident in their bed with no apparatus in place.

During an interview with PSW #114, they reported that the resident no longer required an apparatus while in bed, since their last fall which resulted in an injury. They were unsure as to why the apparatus remained on resident #002's current care plan.

During an interview with Inspector #742, RPN #113 reported that prior to hospitalization, the resident had an apparatus on their bed and chair. RPN#113 indicated that the care plan needed to be updated to reflect the current interventions.

Inspector #742 reviewed the home's policy, " Extendicare Care Planning and Assessments - RC-05-01-01", revised April 2017. The policy directed staff to review, evaluate and revise the effectiveness of the interventions outlined in the care plan on a quarterly basis, following admission, whenever there was a change in the resident's condition, and after completion of each new Minimum Data Set (MDS) assessment.

During an interview with the Director of Care (DOC), they acknowledged that resident #002's care plan was not updated after the resident's care needs had changed and should have been, in accordance with the home's care plan policy as the resident had a significant change in condition. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation (O. Reg.) 79/10 defines:

Physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain;

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 is made by anyone other than a resident; and

Emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CIS was submitted by the home to the Director, which outlined how a few days prior to the report being submitted, PSW #108 observed PSW #107 using profanity towards resident #012 and had been physically aggressive toward the resident during care.

Later, in a second incident PSW #107 was observed aggressively rolling resident #012 in bed causing the resident harm.

Inspector #609 reviewed resident #012's health care records and found in two progress notes which had indicated that the resident had allegedly been physically and verbally abused during care.

During an interview with PSW #108, they outlined how resident #012 had a known tendency towards staff. On a certain day, while providing care, resident #012 displayed the tendency toward PSW #107. The PSW further outlined how PSW #107 used profanity and had been physically aggressive toward the resident.

Later in the shift, PSW #107 provided care a second time to resident #012; whereby, they were observed by PSW #108, rolling the resident aggressively in bed causing them harm.

A review of PSW #107's Human Resources (HR) file found that they had previously emotionally abused and neglected a resident five months previously, to which they received disciplinary action.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program" last updated February 2018, indicated that all residents were to be treated with dignity and respect and protected from all forms of abuse or neglect at all times.

During an interview with the Assistant Director of Care (ADOC), a review of the home's internal investigation of the CIS was conducted and verified that PSW #107 verbally and physically abused resident #012. [s. 20. (1)]

2. A CIS report was submitted by the home to the Director on a certain day, which outlined how on a few days prior to the report being submitted, (before the dinner meal service) PSW #108 observed PSW #107 physically, verbally and emotionally abused resident #012.

The CIS report further outlined how after the dinner meal service, PSW #108 again observed PSW #107 physically abuse resident #012.

During an interview with PSW #108, they verified to Inspector #609 how prior to dinner service, while providing care to resident #012, they observed PSW #107 physically and verbally abuse the resident.

The PSW further outlined how after dinner, they again observed PSW #107 physically abuse resident #012 while providing care.

PSW #108 verified that they did not immediately report to management their observations of abuse by PSW #107 towards resident #012 in the first incident before

dinner, nor immediately when they observed the second incident of abuse by PSW #107 after dinner.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, indicated that anyone who witnessed or suspected abuse or neglect of a resident by another staff member must report the incident immediately- notifying management at a minimum.

A review of PSW #108's HR file, found a letter of discipline for not immediately reporting to their supervisor after abuse had occurred.

During an interview with the ADOC, a review of the home's internal investigation of the CIS was conducted and indicated that PSW #108 received disciplinary action when they failed to immediately report to management, the two incidents of abuse they observed by PSW #107 toward resident #012. [s. 20. (1)]

3. Another CIS report was submitted by the home on a certain day, which outlined a third incident of physical abuse by PSW #107, hours after the second incident had occurred.

The CIS report outlined how PSW #107 was aggressive toward resident #014 during care. They did not stop even when the resident told the PSW they were hurting them.

Inspector #609 reviewed resident #014's health care records and found under a progress note which indicated that the resident reported being abused by a PSW and was described as being very rough with them.

The progress note further indicated that despite being asked to "quit being rough" by resident #014, the PSW continued being rough.

During an interview with resident #014, they described how on a certain day, PSW #107, rushed care causing them pain to a specific area on their body, which had occurred on more than one occasion with PSW #107.

During an interview with the ADOC, a review of the home's internal investigation of the CIS was conducted and they verified that PSW #107 physically and emotionally abused resident #014, when they provided rough care and failed to stop when asked. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. In making a report to the Director under subsection 23(2) of the Act, the licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the incident, which included the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

A CIS report was received by the Director concerning staff to resident abuse. The report indicated that resident #016's family member had witnessed an incident of abuse towards their mother and posted their comments on social media.

During a review of the CIS report, Inspector #577 found that the report indicated that a staff member had witnessed a social media post written by the resident's family member, which alleged abuse towards resident #016. The report had not included a description of the alleged abuse.

A review of the home's policy, "Extendicare-Mandatory and Critical Incident Reporting - RC-09-01-06" revised April 2017, indicated that the critical incident report had to include a description of the type of incident.

During an interview with the DOC, they confirmed with Inspector #577 that the CIS report had not included a description of the alleged abuse. [s. 104. (1) 1.]

2. In making a report to the Director under subsection 23(2) of the Act, the licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including names of staff members or other persons who were present at or discovered the incident.

A CIS report was received by the Director concerning alleged staff to resident abuse. The report indicated that resident #016's family member had witnessed an incident of abuse towards the resident and posted their comments on social media.

During a review of the CIS report, Inspector #577 found that the report had indicated that a staff member had witnessed a social media post written by the resident's family member, which alleged abuse towards resident #016.

A review of the home's policy, "Extendicare-Mandatory and Critical Incident Reporting - RC-09-01-06" revised April 2017, indicated that the critical incident report had to include a description of the individuals involved in the incident including the names of any staff members or other persons who were present at or discovered the incident.

During an interview with the DOC, they acknowledged that they had documented a resident's name instead of the alleged staff member's name, and had not amended the report to include the staff member's name. [s. 104. (1) 2. ii.]

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

Specifically failed to comply with the following:

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where a licensee was required to make a report immediately following an incident, and it was after normal business hours, that the home made the report using the Ministry's method for after hours emergency contact.

A CIS report was submitted by the home to the Director, which outlined two days previously, PSW #108 reported that they had observed PSW #107 physically, verbally and emotionally abused resident #012.

Inspector #609 reviewed the CIS report which indicated that the RN was directed to call the Ministry's reporting line to report the alleged abuse. A further review of the report found no record that the after hours emergency number was contacted.

A review of resident #012's health care records, found in a progress note, that a PSW reported to the RPN who in turn reported to the RN, allegations that a PSW physically abused the resident.

A review of the home's policy titled, "Mandatory and Critical Incident Reporting", last updated April 2017, indicated that the Director of Care or Designate was to make a report immediately following an incident and if it was after normal business hours, report using the Ministry's method for after hours emergency contact.

During an interview with RN #122, they verified that they had notified the Dietary Manager (who was on-call) of the allegations of abuse to resident #012.

During an interview with the Dietary Manager, they verified they were on-call when RN #122 had notified them of the allegations of abuse toward resident #012. They verified that they did not direct RN #122 to call the after hours emergency contact to make a report to the Director. [s. 107. (2)]

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Issued on this 15th day of February, 2019

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

Original report signed by the inspector.