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

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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
Nov 26, 2019	2019_828759_0004	019336-19, 020917-19, 020980-19	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

KEARA CRONIN (759), MICHELLE BERARDI (679), RYAN GOODMURPHY (638)

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): November 19-22, 2019.

The following intakes were completed in this Critical Incident inspection:
- Two Critical Incident reports that were submitted to the Director regarding a fall resulting in an injury and transfer to the hospital.
- One Critical Incident report submitted to the Director regarding alleged staff to resident abuse.

A complaint inspection #2019_805638_0026, was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Nurse Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Workers, housekeepers, and residents.

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

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care was reviewed and revised when the plan of care had not been effective and that different approaches were considered in the revision of the plan of care.

A Critical Incident (CI) report was submitted to the Director that indicated that resident #001 had a fall that resulted in an injury and transfer to the hospital. The injury resulted in a significant change to the resident's status.

Inspector #759 reviewed resident #001’s electronic health care records from specified dates, on Point Click Care. Inspector #759 identified that resident #001 had a specified number of falls.

Inspector #759 interviewed Registered Practical Nurse (RPN) #118, and they indicated that post-fall assessments were completed by the RPN. They further indicated that the care plan was to be reviewed with interventions reassessed immediately.

Inspector #759 reviewed resident #001’s post-fall assessments that were completed for the identified falls. Inspector #759 noted that there was missing information in a specified section of the assessment for a number of the specified falls. Inspector #759 reviewed resident #001’s electronic health care records, and did not identify any documentation relating to the reassessment of fall prevention interventions following any of the identified falls.

Inspector #759 reviewed the policy tilted “Falls Prevention and Management Program” last updated August 2019. The policy indicated that “falls and fall injuries are promptly investigated, tracked and trended, and root causes are identified and addressed to prevent recurrence”. It further directed staff to “update plan of care as necessary”.

During an interview with Inspector #759 and Registered Nurse (RN) #107, who was identified as the home’s Falls Lead, RN #107 indicated that falls interventions should be reassessed after each fall. They further indicated that resident #001 was "changing before the [injury] and had fallen [a specified amount of times before the interventions were reviewed]".

Inspector #759 reviewed resident #001’s care plan with Assistant Director of Care (ADOC) #117. They identified that interventions were implemented prior to the falls and

when resident #001 returned from the hospital. They did not identify any interventions reassessed or trialed during the identified falls.

During an interview with Inspector #759 and the Director of Care (DOC), the DOC indicated that there were no interventions implemented during a specified time frame of all the falls. They indicated that they would have expected interventions to be trialed after the identified falls. [s. 6. (11) (b)]

2. The Licensee has failed to ensure that resident #006's plan of care was reviewed and revised when the plan of care had not been effective and that different approaches were considered in the revision of the plan of care.

Inspector #759 reviewed post-fall assessments over a specified period in 2019 and identified that resident #006 had a specified number of falls.

Inspector #759 reviewed the post-fall assessments for the identified falls and identified that there was information was missing information a number of the assessments.

During an interview with Inspector #759 and ADOC #117, the inspector reviewed resident #006's falls history. Inspector #759 requested ADOC #117 to review resident #006's health care records to identify reassessment of resident #006's falls prevention interventions in-between the identified falls. They indicated that they were not able to identify any reassessed interventions in the care plan between the falls.

Inspector #759 interviewed the DOC and they indicated that they would have expected changes to resident #006's care plan. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is being revised when care set out in the plan has not been effective, and that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

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 policy to promote zero tolerance of abuse was complied with.

Emotional abuse is defined within the Ontario Reg. 79/10 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 CI report was submitted to the Director related to an incident of staff to resident abuse on a specified date. The CI report identified that during resident #003’s care, PSW #102 demonstrated a physically abusive gesture towards the resident and stated a verbally abusive statement while the resident was demonstrating responsive behaviours.

Inspector #638 reviewed the internal investigation notes and identified an interview on a specified date, between PSW #102 and management. The Inspector noted that when PSW #102 was asked if they said a specific statement to the resident, they stated they said a similar statement to the resident. The notes identified that the PSW also demonstrated the gesture. PSW #102 received disciplinary action for their approaches with resident #003.

In an interview with Inspector #638, PSW #106 indicated that they were trained annually on what to watch for related to abuse and neglect. The PSW indicated if they witnessed a staff member demonstrating a specified gesture and stating a specified statement towards a resident, they would immediately report this as a concern to registered staff or management because that would be concerning.

During an interview with Inspector #638, RPN #108 indicated that any incident of abuse was immediately reported to management. When asked if they witnessed a specified gesture and a specified statement towards a resident while demonstrating responsive behaviours was acceptable, the RPN stated “no”.

The home’s policy titled “Zero Tolerance of Resident Abuse and Neglect Program– RC-02-01-01” last updated June 2019, described emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks including infantilization that are performed by anyone other than a resident.

In an interview with Inspector #638, the DOC indicated that the incident between resident #003 and PSW #102 on a specified date, was founded as abuse. The DOC indicated that PSW #102 did not comply with the home’s policy of zero tolerance of abuse with their actions. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of mood and behaviour patterns, including wandering, any

identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted to the Director related to an incident of staff to resident abuse on a specified date. Please see WN #2 for details.

Inspector #638 reviewed resident #003's health care records and identified that on a specified date, the resident displayed responsive behaviours. The Inspector reviewed the resident's Minimum Data Set (MDS) assessment on a specified date which identified that the resident demonstrated specific responsive behaviours over a period of time.

The Inspector reviewed the resident's plan of care and was unable to identify that the resident had the potential to display the specific responsive behaviours.

The Inspector reviewed the resident's electronic assessments that were completed on specified dates. Each assessment identified that the resident demonstrated responsive behaviours a specified number of times per week.

In an interview with Inspector #638, PSW #106 indicated that resident #003 demonstrated responsive behaviours. The PSW indicated they had also heard that the resident had the potential demonstrate another responsive behaviour. The PSW indicated that they referred to the resident's care plan for specific information and interventions related to resident care and that behaviours should have been identified in the resident's care plan.

During an interview with Inspector #638, RPN #110 and RN #107, both indicated that registered staff were in charge of updating the resident specific care plan to ensure that the information was kept current. Both staff members indicated that resident #003 demonstrated specific responsive behaviours. The Inspector reviewed what was identified in the resident's plan of care and both RPN #110 and RN #107 indicated that although it was difficult to identify triggers and interventions for the resident, registered staff should have updated the plan to include the types of behaviours the resident had the potential to demonstrate.

The home's policy titled "Responsive Behaviours – RC-17-01-04" indicated that the interdisciplinary team was to develop a care plan that includes a description of the behaviour, triggers to the behaviour, preventative measures to minimize the risk of the behaviour developing or escalating, resident specific interventions to address behaviours

and strategies staff are to follow if the interventions are not effective.

In an interview with Inspector #638, the DOC indicated that registered staff were to ensure that the care plan was kept up to date so that staff were able to be aware of the resident behaviours and to determine interventions. The DOC indicated they had identified this concern and were working to ensure all staff were aware of their responsibilities to update care plans when behaviours were identified. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for a resident who is exhibiting responsive behaviours, must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The Licensee has failed to inform the Director in writing, of the analysis and follow-up action of the incident within 10 days of becoming aware of the incident, or sooner if required by the Director.

A CI report was submitted to Director on a specified date as a result of a significant change to resident #001's health status. Please see WN #1 for more details.

Inspector #759 reviewed the CI report and identified missing information regarding the analysis and follow-up action.

Inspector #759 reviewed the "Critical Incident Reporting (ON)" policy last updated June 2019, that indicated the home must "Amend the Critical Incident Report, as appropriate, with new or additional information as it becomes available and submit to the MOHLTC within established time frames".

During an interview with Inspector #759 and the DOC, they indicated that the analysis and follow-up was required to be submitted the day the resident "comes back". Inspector #759 reviewed the CI with the DOC and shared that the analysis and follow-up was incomplete as of a specified date. The DOC indicated that the CI report should have been completed in a timely manner and was submitted late. [s. 107. (4) 4.]

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.