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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Oct 22, 2015;	2015_391603_0024 (A3)	015793-15	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 YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

SYLVIE LAVICTOIRE (603) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

**Extendicare York has requested an extension for full compliance date for Orders #001,
#002, #003 and #006, from November 2, 2015 to December 2, 2015. For this reason, Inspector #603 has changed the full compliance date for Orders #001, #002, #003 and #006, from November 2, 2015 to December 2, 2015.**

Issued on this 22 day of October 2015 (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

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

SYLVIE LAVICTOIRE (603) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 20-24 and July 27-30, 2015

During the course of the inspection, the inspector(s) reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a daily walk-through of the home, observed the delivery of resident care, staff to resident interactions, and medication administration. The following Ministry logs were also inspected: S-000919-15, S-000920-15, S-000699-15, S-000580-14, S-000824-15, S-000948-15, S-000934-15, S-000859-15, S-000487-14, S-000510-14, S-000571-14, S-000852-15, S-000675-15, and 001366-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nursing Staff (RNs, RPNs), Physiotherapist, Dietitian, Dietary Aid, Maintenance Staff, Housekeeping Staff, RAI Coordinator, Behavioral Support Ontario Staff, Personal Support Workers, Residents, and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

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

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

20 WN(s)
10 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 :

1. The licensee has failed to ensure that there was a written plan of care that sets out clear directions to staff and others who provide direct care to resident #018.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that on a certain date, resident #018 was unhappy with the manner in which a staff member spoke with them and also that the care was not provided to them in a timely manner. Resident #018 explained that the staff member raised their voice when responding to their call bell. The resident stated: "They yelled at me". The resident was upset because of the lack of care. The resident then stated: "I'm so fed up with this life". According to the CI, the long-term actions to correct this situation and prevent recurrence were to update and adjust the care plan as the resident's care needs changed and staff would provide care in pairs.

Inspector reviewed the home's investigation which concluded that they were satisfied that the complaint was not as a result of S#118's actions or the actions of any employee of the home.

Inspector reviewed the progress notes from a period of 6 weeks, which indicated resident #018 displayed responsive behaviors on 8 different days during these 6 weeks.

Inspector #603 reviewed resident #018's care plan for the same period of 6 weeks. These care plans had no focus related to responsive behaviors, in fact, both care plans had a focus for mood state. However, there were no interventions to address this focus. The resident continued to have behaviors and in the latter care plan, there was no direction for staff to provide care in pairs.

Inspector #603 interviewed S#110 who explained that the probable reason for not identifying a focus related to responsible behaviors in the care plan was that the resident only displayed these behaviors when they had a specific health condition the resident periodically had. On review of the care plans, there was no focus to address a specific health condition the resident periodically had. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care that sets out clear directions to staff and others who provide direct care to resident #028.

On July 28, 2015 at 0815hrs, Inspector #603 reviewed resident #028's health care record and noted that the resident had a fall and sustained an injury. The attending physician ordered complete bed rest for one week.

On July 29, 2015, Inspector #603 reviewed resident #028's care plan. The care plan had a focus for bathing and the interventions included to give a bed bath daily and prn while on bed rest. Another focus was seen in which the interventions identified assistance for showers.

On review of the resident's health care record, Inspector #603 noted that the Dietitian ordered a specific diet and texture. The care plan had a focus on diet and were to provide a the same specific diet and texture. On review of the home's Meal Service Report, resident #028 was to receive a specific diet and a different texture. During an interview with S#143, they indicated that staff utilize this form in order to identify what kind of food is to be prepared for each meal. During an interview with S#130, they explained that the specific diet and texture information had not been communicated to the dietary department and transferred to the Meal Service Report because the orders had not been co-signed by two staff members.

On July 28, 2015 at 0840hrs, Inspector #603 observed resident sleeping in bed with side rails engaged. During an interview with S#142, they explained that resident #028's POA had requested side rails to be engaged. Inspector #603 reviewed resident #028's care plan. The care plan had a focus for bed mobility and the

interventions indicated a different usage for side rails. During a discussion with S#130, they explained that all staff refer to the care plan in order to determine the required care.

LTCHA, 2007 S.O. 2007, s. 6. (1) (c) was issued previously as a WN and CO during Inspection #2015_283544_0006, a WN and VPC during Inspection #2014_331595_0010, a WN during Inspection #2013_138151_0010, a WN and CO during Inspection #2013_138151_0008. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On July 21, 2015, during stage 1 of the Resident Quality Inspection, Inspector #617 conducted an interview with resident #003's family member and substitute decision maker (SDM). The family member reported that they were not notified of the medication changes that were noted on a medication list they had reviewed.

Inspector #617 reviewed resident #003's progress notes, which indicated that the physician had assessed the resident, determined there was a specific health condition, and ordered a treatment. Staff #126, who was the author of the note indicated that they would make the SDM aware of the change. Inspector #617 reviewed the physician's orders, which indicated a treatment.

On July 28, 2015 at 1024, Inspector #617 interviewed resident #003's SDM who reported that they were aware the physician was scheduled to assess the resident but were not aware of any treatment started. Inspector #617 interviewed S#126 who reported that resident #003's alternate contact was present when the physician attended and prescribed a treatment. Staff #126 confirmed that they did not directly inform the SDM of the resident's new treatment.

LTCHA, 2007 S.O. 2007, s. 6. (5) was issued previously as a WN and CO during Inspection #2015_283544_0006, a WN and CO during Inspection #2013_138151_0008, a WN and VPC during Inspection #2013_140158_0001. [s. 6. (5)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

During this inspection, Inspector #612 observed S#141 assist resident #005 to the washroom and then leave the room and walk down the hallway. Shortly after, S#141 later returned to assist resident from the toilet.

Inspector #612 reviewed the resident's care plan and noted under the toileting focus that resident #005 cannot be left on toilet unattended.

Inspector interviewed S#141, S#109, and S#130 who confirmed that resident #005 cannot be left unattended on the toilet as indicated in the care plan. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #012 and #013 as specified in the plan.

During this inspection, Inspector #617 observed the lunch meal service on a specific floor from 1245hrs to 1400hrs. Inspector #617 observed S#107 feeding resident #012 who was specifically positioned in their chair.

Inspector #617 reviewed resident #012's care plan. The care plan indicated the resident required a specific diet and texture. The care plan did not give direction to position the resident in a specific position during meals.

During this inspection, Inspector #617 observed the lunch services on a specific unit from 1245hrs to 1400hrs. Inspector #617 observed S#108 feeding a specific diet and texture to resident #013 who was specifically positioned in their chair.

Inspector #617 reviewed resident #013's care plan, which indicated the resident required a specific diet and texture. The care plan did not give direction to place the resident in a specific position for feedings. [s. 6. (7)]

6. The licensee has failed to ensure that the plan of care was provided to resident #003 as specified in the plan.

Inspector #617 reviewed resident #003's health care records which indicated the resident had many diagnoses. The resident required assistance with activities of daily living. Resident #003 used a specific chair for locomotion and a specific transfer device from bed to and from wheelchair.

On two days during the inspection, Inspector #617 observed resident #003 in their

room, sitting in a specific chair with a restraint on. On the second day during the inspection, Inspector also observed resident #003 in the dining room with a specific restraint on.

Inspector #617 interviewed S#137 who reported that the restraint for resident #003 had not been assessed as a restraint. The restraint had not been added to the care plan and was being used as per family request. Inspector #617 interviewed S#138 who reported that the restraint was used for positioning resident #003.

Inspector #617 interviewed resident #003's family member who stated that it was the intention of the family to use the restraint when resident #003's condition worsened. The family member stated that the use of the specific restraint was no longer needed.

Inspector #617 reviewed the care plan which did not indicate the use of a specific restraint for positioning.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as WN and VPC during Inspection #2014_331595_0010, a WN and CO during Inspection #2013_138151_0008, a VPC during Inspection #2013_140158_0001. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 006,001,002

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 policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

On July 23, 2015, Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that a PSW working at the home reported to the RPN, that resident #019 had complained to them, that a PSW was rude to them. The CI indicated that the resident rang the bell for assistance. The resident stated that the PSW said: "You're too lazy to use the bathroom". The resident stated that this PSW had been rude on other occasions but the resident had not reported this as they were afraid of future negative interactions with this PSW.

Inspector #603 reviewed the home's policy on Resident Abuse - Staff To Resident, Policy Reference #OPER-02-02-04. The policy indicated that there is zero tolerance of abuse toward a resident. All residents are ensured dignity and respect. Resident abuse will result in termination. Abuse includes emotional abuse and verbal abuse.

The home did an investigation regarding verbal abuse and found S#111 to be in violation of Extendicare York's policies on abuse. Subsequently, S#111 received a disciplinary action. [s. 20. (1)]

2. The licensee has failed to ensure that the policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. In 2015, the night shift RPN found resident #017 at the nursing desk, sitting in their wheelchair with two specific restraints on. The resident was having responsive behaviors and wanted to go to bed. The RPN assessed that the resident was displaying a health condition and offered the resident treatment which the resident accepted. The RPN called the RN in charge and was asked to consult on the care plan, and noted that the restraints were not an acceptable intervention, and there was no order for the restraints. On this finding, the RN instructed the RPN to immediately

remove the restraints, to provide comfort measures to the resident, to assess the resident for any negative outcomes and to document the event.

Inspector #603 reviewed the home's policy on Resident Abuse - Staff to Resident, Policy Reference #OPER-02-02-02. The policy indicated there is zero tolerance of abuse toward a resident. The home is committed to providing a safe and supportive environment in which all residents are ensured dignity and respect. Abuse includes physical abuse and emotional abuse. Resident abuse will result in termination.

Inspector #603 reviewed the home's investigation reports from this CI. Staff #112 was found to be in violation of the home's policies on Least Restraint and Prevention of Resident Abuse and for this reason, S#112 received a disciplinary action. [s. 20. (1)]

3. The licensee has failed to ensure that the policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

Inspector #575 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that according to the progress notes, resident #021 advised an RPN that they were yelled at by a staff member of the home. The RPN advised the RN of the incident and the RN identified that they would follow up with the resident, however they did not. The CI further indicated that the recorder of the progress notes did not alert management to the event and no CI was submitted. The incident was not investigated until 14 months after the incident occurred.

The Inspector reviewed the home's policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04 version November 2013. Under the section 'Responding/Reporting-Suspected or witnessed abuse', #3 indicated that staff are to immediately report (verbally) any suspected or witnessed abuse to the Administrator, DOC, or their designate who must report the incident as required by provincial legislation and jurisdictional requirements...'. The policy further indicated that anyone who suspects or witnesses abuse and/or neglect that causes or may cause harm to a resident is required to contact the Action Line and failure of staff to verbally report the incident to the Administrator, DOC or their designate immediately could result in disciplinary action.

In addition, the policy outlined that annually, staff would receive education and training on the abuse policy as well as identification, prevention and reporting as part of the home's in-service training plan. The Inspector reviewed the training records and S#110 confirmed that the two staff involved in the CI did not receive training in 2014,

and one of the same staff had not yet received training in 2015 to date. [s. 20. (1)]

4. The licensee has failed to ensure that the policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

Inspector #575 reviewed a Critical Incident (CI) Report regarding alleged staff to resident abuse. The Inspector noted that as a result of the abuse investigation, S#146 was in violation of the home's policy and received a disciplinary action.

The Inspector noted that the home's policy indicated that resident abuse would result in termination. During an interview, S#110 indicated that the home had requested corporate to change the current policy to reflect what they currently do. Staff #110 explained that the home has another policy outlining progressive discipline and S#110 indicated that these policies contradict each other.

In addition, the policy outlined that annually, staff would receive education and training on the abuse policy as well as identification, prevention and reporting as part of the home's in-service training plan. The Inspector reviewed S#146's file and training records and noted that the staff member did not receive training in 2014. Staff #110 confirmed that S#146 did not receive training in 2014 as required by policy. [s. 20. (1)]

5. The licensee has failed to ensure that the policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

Inspector #575 reviewed two Critical Incident (CI) Reports regarding alleged staff to resident abuse. In the first CI, it was reported that S#144 failed to care for resident #024's. In the second CI, it was reported that S#145 verbally abused and neglected resident #024 by demeaning the resident.

The Inspector noted that the first CI occurred in 2014 and the second CI occurred one day later. On review of the documentation, Inspector noted that both CI's were not submitted to the Director until two or three days later. In both CI's, the staff who reported sent an email/note to the DOC, days after the incident and did not report to the nurse in charge, nor the manager on call. The home's policy outlined that if abuse was suspected or witnessed, staff are to immediately report (verbally) to the Administrator, DOC, or their designate.

As a result of the investigation for the first CI, S#144 received a letter of discipline. The Inspector noted that the home's policy indicated that abuse would result in

termination and neglect could result in discipline up to and including termination; however, where an act of neglect is determined to fall within the definition of abuse (e.g., resident abuse by neglect, then the result would be termination).

In addition, the policy outlined that all staff are responsible to ensure that they understand and comply fully with the Resident Abuse - Staff to Resident policy and procedures.

LTCHA, 2007 S.O. 2007, s. 20 (1) was issued previously as WN and VPC during Inspection #2015_320612_0006, a WN during Inspection #2014_331595_0010, a WN during Inspection #2013_138151_0008. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 003

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan for the home that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

On July 21, 2015, Inspector #617 conducted an interview with resident #003's family member who reported that there is no air conditioning on the unit's corridor. According to the family member, when the outside temperature reaches over 25 degrees Celsius, it's stifling in the building and resident #003 responds negatively to the heat.

Inspector #617 reviewed the home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual regarding Care of Resident during hot weather, last updated December 2002. The policy identified preventative and emergency measures for dry and humid air temperature reading thresholds to be put in place, to prevent against heat related illnesses. Staff #102 submitted to Inspector #617 a daily log sheet dated July 1 to 23, 2015, which identified daily building temperature readings for dry air only. Inspector #617 interviewed S#124 who reported that they took the recorded temperatures in the air cooled dining room from the thermostat daily, in the morning. Staff #124 reported that they do not take daily humidity readings. Staff #102 confirmed that since 2013 there has been a gap in monitoring the humidity in the home and the staff have not been monitoring the threshold according to policy, for identifying when the preventative or emergency measures are to be put in place.

The home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual for Care of

Resident during hot weather, last updated on December 2002, indicated that preventive measures are to be put in place when the dry temperature is above 28 degrees Celsius. The preventative measures include the following:
- close the window, drapes and blinds during the day
- ensure residents are adequately hydrated
- alter meal plans to provide lighter, cool meals which contain extra fluids
- encourage loose clothing
- remove excess bedding
- reduce recreational programs
- restrict outdoor activities
- encourage residents to remain in cooler areas

On Jul 27, 2015 at 1414hrs, Inspector #617 measured the temperature in one specific corridor and the result was 29.1 degrees Celsius. Inspector #617 observed the following in the rooms of the same corridor:
- only three of the sixteen residents' rooms had their windows and curtains closed.
- all existing floor and table fans were on and working in the residents' rooms however not all rooms had fans
- residents were found sleeping in their beds wearing long sleeved pants and shirts and were covered with blankets.
- resident #026 was observed by Inspector #617 to be wearing a long sleeved shirt and long pants and their face was red in color. Resident #026 was walking in the hallway and demonstrating responsive behaviors. Staff #108 reported that resident #026 was having responsive behaviors on that day possibly due to the hot temperature on the unit. On July 27, 2015 at 1440hrs, Inspector #617 interviewed S#107 and S#125 who reported that they had not been notified that there was a hot weather protocol in effect. On July 27, 2015, Inspector #617 observed that the lunch served on a specific unit was hot with steam coming out of the servery. [s. 20. (1)]

2. The licensee has failed to ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents.

On July 21, 2015, Inspector #617 conducted an interview with resident #003's family member who reported that there is no air conditioning in the resident #003's corridor and when the outside temperature reaches over 25 degrees Celsius, it's stifling in the building and resident #003 responds negatively to the heat.

Inspector #617 toured the a specific unit and the main lobby with staff #102 who

reported the following regarding air conditioning in the home:
- the home does not have centralized air conditioning
- condensers are located on the roof top which provide air conditioning by forced air through a ceiling vent to only the main floor's activity room and to each nursing station on all residential floors
- a chiller is located on the rooftop that supplies air conditioning to each dining room through 2 DX coils for all floors.
- window air conditioners are allowed in resident rooms and are supplied and maintained by residents/substitute decision makers. Staff #102 reported that the home doesn't keep a log of the units currently being used by residents.

On July 29, 2015, Inspector #617 reviewed the home's total census which identified 283 residents, presently living in the home. More specifically, there were 57 residents living on a specific unit. There was a total of 6 cooled rooms in the building (five dining rooms - one on each unit and one activity room). If all the residents were attending the six rooms there would be 47 residents in each of the cooled rooms.

On July 20, 2015 at 1730hrs, Inspector #617 inspected a meal service in a specific dining room. There were 55 of the 57 residents seated in this dining room. A thermostat was located on the pillar, in the middle of the dining room, which indicated that the temperature was just below 28 degrees Celsius.

The home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual for Care of Resident during hot weather last updated on December 2002, indicated that there should be at least one cooling area on each floor of the building where residents reside. These areas should provide adequate space (e.g. 15 square feet per resident) for each resident to prevent increased heating due to overcrowding. On July 20, 2015, while observing a specific dining room service, Inspector #617 observed 55 residents seated at their tables, and there was very little room to move, in between the tables and residents. The 55 residents in the air conditioned room provided by the home for the one unit, exceeded the number of residents (40) as identified in the legislation. [s. 20. (2)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

During the initial tour of the home on July 20, 2015, Inspector #612 observed treatment carts stored beside the nursing stations in the hallways on 2 different units. Both treatment carts were left unlocked and unsupervised and there were residents in the hallways. Inspector #612 was able to access a treatment solution and syringe needle tips, and no staff were present.

On July 24, 2015, Inspector #612 observed an unlocked and unsupervised treatment cart which was stored in the hallway, beside the nursing station, on a specific unit and there were residents in the hallways. Inspector was able to access a treatment solution and syringe needle tips, and no staff were present.

Inspector #612 interviewed registered S#114 and S#122 who both confirmed that the carts should be locked at all times. Inspector #612 also interviewed S#110 who confirmed that the home's expectation is to have all treatment carts locked when not in use, as the carts are stored in an area where they are accessible to residents and contain potentially harmful substances and objects. [s. 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 ensuring that all treatment carts are stored and locked to ensure a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: 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 :

1. The licensee has failed to ensure that 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, is complied with.

Inspector #617 reviewed the home's policy #INFE-03-01-09 entitled Infection Surveillance and Control for Contact Precautions which was last updated on January 2013. The policy indicated that the procedure for registered staff is to place a contact precaution sign on the resident's room door indicating the personal protective equipment required to be worn by staff providing care. Inspector #617 reviewed the daily infection surveillance form identifying that resident #007, #029, and #030 all required contact precautions. On July 29, 2015, Inspector #617 observed that these residents' rooms did not have contact precautions sign on the doors. [s. 8. (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 ensuring that the home's policy #INFE-03-01-09 entitled Surveillance and Control for Contact Precautions is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident is restrained by a physical device, only if the restraining was included in the plan of care.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. According to the report, the night shift RPN found resident #017 at the nursing desk in their wheelchair with two restraints on. The resident was displaying responsive behaviors. The RPN assessed that the resident was displaying a specific health condition and offered the resident treatment, which the resident accepted. The RPN had called the RN in charge and was asked to consult on the care plan and noted that the restraints were not an acceptable intervention. On this finding, the RN instructed the RPN to immediately remove the restraints, to provide comfort measures to the resident, to assess the resident for any negative outcomes, and to document the event.

Inspector #603 reviewed resident #017's care plan, which did not include the use of restraints. Inspector #603 interviewed S#112, who explained that the resident was never to be restrained.

Inspector #603 reviewed resident #017's health care record and there was no consent for restraints nor was there a physician's order for restraints at the time of the incident. [s. 31. (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 ensuring that a resident is restrained by a physical device, only if the restraining is included in the plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 received oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures.

Inspector #617 reviewed the health care record for resident #003. The May 26, 2015, RAI MDS assessment for resident #003 indicated for oral status that daily cleaning of teeth or dentures or daily mouth care by staff occurred during the assessment period. Inspector #617 reviewed resident #003's care plan which indicated a focus of oral/dental status and staff are to assist with oral care, two times a day.

Inspector #617 interviewed S#129 and S#108 who reported that resident #003 had a specific health condition at the time of the assessment. Staff #129 and S#108 also explained that the staff were responsible for assisting the resident with mouth care. One day during the inspection, Inspector #617 observed staff #138 assist the resident with oral care.

Inspector #617 reviewed the home's policy #RESI-05-07-14 entitled Resident Care Manual Activities of daily living for personal hygiene/grooming related to mouth care, last updated on December 2002. The policy indicated that if the resident is not capable of doing own mouth care, the staff is to follow the mouth care routine as per the resident's care plan.

Staff #108 showed Inspector #617 on the Point of Care (POC) kiosk for resident #003 that oral care is prompted as the following question, "was the oral care completed?" and for the day and evening shift PSWs are to document that oral care was performed

for the resident. Staff #128 submitted to Inspector #617 a POC audit report for the documentation of oral care for resident #003, which indicated that oral care was documented only once a day during that period of time. Inspector #617 interviewed staff #110 who confirmed that if the PSW is prompted to document care and didn't document it, then resident #003 didn't receive oral care a second time, in the evening, as identified in their plan of care. [s. 34. (1) (a)]

2. The licensee has failed to ensure that resident #003 received oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

Inspector #617 reviewed resident #003's health care records. The admission progress notes indicated that registered staff completed an oral assessment. The May 26, 2015 RAI MDS oral assessment for resident #003 indicated that daily cleaning of teeth or dentures or daily mouth care by staff occurred during the assessment period. An offer of annual dental assessment was not evident in the health care records to resident #003.

Inspector #617 interviewed S#108 who reported that resident #003 had a specific health condition. Inspector #617 interviewed S#126, who reported that an annual dental assessment was not offered to resident #003.

On July 28, 2015, Inspector #617 interviewed S#110 who reported that there is no dental hygienist contracted for the home but they are currently in the process of securing one. Staff #110 confirmed that resident #003 was not offered an annual dental assessment. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents, including resident #003 receive oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening including the cleaning of dentures, and an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision maker, if payment is required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no prohibited restraint devices are used on a resident.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. According to the report, the night shift RPN found resident #017 at the nursing desk in their wheelchair with a 2 restraints on. The resident was displaying responsive behaviors and wanted to go to bed. The RPN assessed that the resident was displaying a specific health condition and offered the resident treatment, which the resident accepted. The RPN had called the RN in charge and was asked to consult on the care plan and noted that the restraints were not an acceptable intervention. On this finding, the RN instructed the RPN to immediately remove the restraints, to provide comfort measures to the resident, to assess the resident for any negative outcomes, and to document the event.

Inspector #603 reviewed the home's policy Physical Restraints #RESI-10-01-01 which indicated Prohibited physical restraints included: sheets, wraps, tensors or any types of strips or bandages used other than for therapeutic purposes. The prohibited restraints also included limb restraints.

The employer determined that the actions in 2015 were in violation of Extendicare York's policies on Least Restraint and Prevention of Resident Abuse. Staff #112 received a disciplinary action as a result. [s. 35. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that no prohibited restraint devices are used on any resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During the inspection, Inspector #617 observed the lunch service on a specific unit from 1245hrs to 1400hrs. Inspector observed resident #012 being fed their entire meal in a specific position.

Inspector #617 reviewed resident #012's care plan. The care plan indicated the resident required a specific diet and texture. The care plan did not give direction to place the resident in a specific position during meals.

During the inspection, while observing the lunch service, Inspector #617 observed resident #013 in a specific position while being fed.

Inspector #617 reviewed resident #013's care plan. The care plan indicated The resident required a specific diet and texture. The care plan for resident #013 did not give direction for a specific positioning.

During the inspection, while observing the lunch service, Inspector #617 observed S#106 standing in front of resident #014 who was sitting in a specific position. Inspector #617 interviewed S#106 who reported that it is the home's policy for staff to sit while assisting to feed residents to ensure safe positioning of residents who require assistance. [s. 73. (1) 10.]

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 the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Inspector #603 interviewed S#110 who explained that all staff receive annual retraining on Resident Abuse. Inspector #603 reviewed the home's policy Resident Abuse - Staff to Resident Policy #OPER-02-02-04 version November 2013. The policy indicated that as a minimum education requirement, all staff must receive education during orientation and annually thereafter, on the Resident Abuse - Staff to Resident policy as well as policies and procedures that support identifying and preventing resident abuse. Inspector #603 randomly reviewed S#112's personnel file and there was education for Abuse and Neglect for May 21, 2015, but none for the year 2013 and 2014. Inspector interviewed S#110 who confirmed that S#112 did not receive education on Abuse and Neglect or Resident Abuse - Staff to Resident policy for the year 2013 and 2014. [s. 76. (4)]

2. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Inspector #603 interviewed S#110 who explained that all staff receive annual retraining related to the home's policy to promote zero tolerance of abuse and neglect of residents. On review of the home's policy on Resident Abuse - Staff to Resident, reference #OPER-02-02-04, version November 2013, under minimum education requirements, all staff must receive education during orientation and annually thereafter, on the Resident Abuse Policy. Inspector reviewed S#118's personnel record and the staff member did not receive education on Resident Abuse Policy in 2014. Staff #110 confirmed that S#118 did not receive the training in 2014. [s. 76. (4)]

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 all staff receive annual retraining relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

On July 28, 2015, Inspector #612 and S#102 observed a housekeeping cart left unattended in the hallway outside the housekeeping storage room on a specific unit. Inspector observed that the cabinet where chemicals were stored was not locked and another cleaning product was hanging on the side of the cart. The cart was left accessible to numerous residents passing by in the hallway.

Inspector interviewed S#140 and S#102 who stated that the cart contains universal disinfectant, washroom cleaner, and neutral cleaner. Staff #102 confirmed that chemicals are required to be locked in the cabinet on the cart. Inspector observed the bottles labelled with a WHIMIS symbol identifying that the products were toxic. Upon review of the WHIMIS binder with S#102 it was noted that the chemicals could cause irritation to the skin and respiratory system if used incorrectly.

Inspector reviewed the home's policy titled Housekeeping- Supply Management, reference #HKLD-05-01-06. The policy stated to ensure that chemicals required on housekeeping cart are kept locked and inaccessible to residents. No cart is allowed to be on the unit with chemicals in the cabinet unless chemicals can be secured so that they are inaccessible to residents. [s. 91.]

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 all hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On July 24, 2015, Inspector #612 and S#114 observed the controlled drug storage system on a specific unit. The controlled medications were stored in a single locked drawer in the medication room. Inspector confirmed with S#130 that there is only a single lock on the drawer where controlled medications are stored in the medication room.

Inspector spoke with S#135 who confirmed that they thought the door to the medication room counted as the second lock and did not realize they needed the double locked stationary cupboard in the locked area. [s. 129. (1) (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 ensuring that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

Inspector #575 reviewed the home's training/education records related to abuse recognition and prevention for 2014 and 2015 to date. The Inspector asked the S#110 to confirm the number of staff that completed the training/education in 2014 and 2015 to date. Staff #110 provided the Inspector with a document that indicated in 2014, 249/314 staff completed the training/education and in 2015 to date 279/324 staff completed the training/education. Not all staff were provided training/education in abuse recognition and prevention in 2014. [s. 221. (2)]

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 all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member, to be implemented voluntarily.

WN #14: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

During the inspection, after lunch, Inspector #612 observed S#141 assist resident #005 to their room, leave resident's room, and walk down the hallway into another resident's room. Inspector entered resident #005's room and observed that the door to the bathroom was open and resident #005 was exposed. Staff #141 then returned to the resident's room and assisted resident.

Inspector #612 spoke with S#141 who confirmed that the washroom door should have been closed to maintain resident's privacy. [s. 3. (1) 8.]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, its furnishings, and equipment were maintained in a safe condition and in a good state of repair.

Inspector #612 observed the sinks in three different resident's washrooms to not be maintained in a good state of repair. Inspector noted the sink in one room to be loose from the wall and the caulking surrounding the sink in the other two rooms was cracked and peeling.

Inspector interviewed S#102 who confirmed that those sinks required repair and maintenance. Staff #102 reported that they would have maintenance staff follow up with repairing the sinks. [s. 15. (2) (c)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations.

Inspector #575 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that according to the progress notes in 2013, resident #021 advised a RPN that they were yelled at by a staff member of the home. The CI further indicated that the recorder of the progress notes did not alert management to the event and the CI was not reported to the Director immediately.

The RPN advised the RN of the incident and the RN identified that they would follow up with the resident, however they did not. The incident was not investigated until 14 months later. [s. 23. (1) (a)]

WN #17: 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 has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

On July 20, 2015, Inspector #612 conducted an initial tour of the home and noted in the spa rooms, nail clippers, shampoo bottles, and soap bars that were unlabelled and had been used.

Inspector #612 interviewed S#114 who confirmed that the resident's personal items are to be labelled within 48 hours of admission and of acquiring new items. [s. 37. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviors, the behavioral triggers for the resident are identified, strategies are developed and implemented to respond to these behaviors, and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that resident's responses to interventions are documented.

Inspector #603 reviewed a Critical Incident (CI)Report which was reported to the Director. The CI indicated that in 2014, resident #018 was unhappy with the manner in which a PSW spoke with them and also that care was not provided to them in a timely manner. Resident #018 explained that the PSW raised their voice when responding to their call bell. The resident stated: "They yelled at me". The resident was upset because of the lack of care. The resident then stated: "I'm so fed up with this life". According to the CI, the long-term actions to correct this situation and prevent recurrence were to update and adjust the care plan as the resident's care needs changed and staff would provide care in pairs.

Inspector reviewed the home's investigation which they concluded, they were satisfied that the complaint was not as a result of S#118's actions or the actions of any employee of the home.

Inspector reviewed 6 weeks of the resident's progress notes, which indicated that during that time, resident #018 displayed responsive behaviors on 8 different days during the 6 weeks.

Inspector #603 reviewed resident #018's care plan for two different time frames around the above time frame. These care plans had no focus related to responsive behaviors or behavior triggers, in fact, both care plans had a focus on Mood state. There were no interventions to address the Mood state focus. The resident continued to have responsive behaviors and there was no direction for staff to provide care in pairs.

Inspector #603 interviewed S#110 who explained that the probable reason for not identifying a focus related to responsible behaviors in the care plan was that the resident only displayed these behaviors when they had a specific health condition, the resident periodically has. On review of the care plans, there was no identification to address a specific health condition, the resident periodically has. [s. 53. (4)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On July 23, 2015, Inspector reviewed a Critical Incident (CI) Report which was reported to the Director. According to the CI report, a PSW working at the home reported to the RPN that resident #019 had complained to them, that a PSW was rude to them. The resident stated that this PSW had been rude on other occasions but the resident had not reported this as they were afraid of future negative interactions with this PSW.

On review of the CI, the resident's relative and/or substitute decision maker was not contacted. The response on the CI indicated that this was not done because the resident is capable and able to make informed decisions. While interviewing S#110, they explained that they did not know who else they should have contacted. On review of resident #019's health care record, the primary contact and SDM was another family member and a phone number was listed.

Inspector #603 reviewed the home's policy on Resident Abuse - Staff to Resident. The policy indicated that upon notification, the Administrator/Director of Care/Designate must immediately notify the resident's substitute decision-maker/power of attorney, if any and family, if the resident experiences abuse that resulted in distress that can be detrimental to the health and well-being of the resident. [s. 97. (1) (a)]

2. The licensee has failed to ensure that resident #019's substitute decision-maker was notified of the results of the alleged abuse investigation immediately upon its completion.

On July 23, 2015, Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. According to the CI, a PSW working at the home reported to the RPN that resident #019 had complained to them, that a PSW was rude to them. The resident stated that this PSW had been rude on other occasions but the resident had not reported this as they were afraid of future negative interactions with this PSW.

On review of the CI, the home did their investigation and concluded that S#111's actions were abusive and failed to follow the home's policy on abuse and neglect and the MOHLTC's legislation. Staff #111 subsequently received a disciplinary action.

On review of the CI, the resident's relative and/or substitute decision maker was not contacted. The response on the CI indicated that this was not done as the resident is capable and able to make informed decisions. On interview with S#110, they explained that they did not know who else they should have contacted. On review of resident #019's health care record, the primary contact and substitute decision maker was a another family member and a phone number was listed.

Inspector #603 reviewed the home's policy on Resident Abuse - Staff to Resident # OPER-02-02-04 which indicated that upon notification, the Administrator/Director of Care/Designate will promptly notify the resident and their substitute decision maker/power of attorney, if any, of the investigation results. [s. 97. (2)]

3. The licensee has failed to ensure that resident #022's substitute decision-maker (SDM) was notified of the results of the alleged abuse investigation immediately upon its completion.

Inspector #575 reviewed a Critical Incident (CI) Report in regards to an alleged staff to resident abuse that occurred on in 2015. During an interview, S#110 indicated that normally they would make a progress note to indicate that they informed the SDM of the results of the investigation. Staff #110 was not able to find any documentation that they informed the SDM of the investigation results and indicated that they "might have missed that". [s. 97. (2)]

WN #20: 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:
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).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names

of any staff members who were involved in the incident.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. According to the CI, the night shift RPN found resident #017 to be a the nursing desk, in their wheelchair with two restraints on. The resident was displaying responsive behaviors and wanted to go to bed. The RPN assessed that the resident was displaying a specific health condition and offered the resident treatment, which the resident accepted. The RPN had called the RN in charge and was asked to consult the care plan and noted that these restraints were not an intervention. On this finding, the RN instructed the RPN to immediately remove the restraints, to provide comfort measures to the resident, to assess the resident for any negative outcomes and to document the event.

On review of the CI, Inspector noted that four staff members who were involved in the incident were not named. Staff #112 applied the 2 restraints, S#115 and S#116 were in attendance when the resident was restrained, and S#117 was responsible for overseeing the PSWs care to the resident. Staff #112, received a disciplinary action for violating the home's policies on Least Restraint and Prevention of Resident Abuse. Staff #115 and #116 received a disciplinary action for violating the home's policy on Least Restraint. Staff #117, received a disciplinary action for failing to ensure that PSWs are providing safe care in accordance with the home's policies. In discussion with S#110, they noted that they had not named all staff involved on the CI report however, were able to give list to the Inspector. [s. 104. (1) 2.]

2. The licensee has failed to ensure that if unable to provide a final report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Inspector #575 reviewed a Critical Incident (CI) Report regarding alleged staff to resident abuse which was reported to the Director. The Inspector noted the CI was amended with the results of the investigation (final report) - 32 business days after the original CI was submitted. [s. 104. (3)]

3. The licensee has failed to ensure that if unable to provide a report final within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Inspector #575 reviewed two CI's of alleged staff to resident abuse towards resident #024. Both CI's were reported to the Director in 2014, were amended 2 weeks later and again 5.5 weeks later (final reports). The results of the investigation were not reported on either CI until 60 business days after the original CIs were submitted. [s. 104. (3)]

Issued on this 22 day of October 2015 (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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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) :	SYLVIE LAVICTOIRE (603) - (A3)
Inspection No. / No de l'inspection :	2015_391603_0024 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	015793-15 (A3)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 22, 2015;(A3)
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Arlene Lesenke

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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: 2015_283544_0006, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

(A3)
The licensee shall prepare, submit, and implement a plan to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. The plan will include the following:

1. A process to ensure that the plan of care for each resident is reviewed, updated, and identifies clear and current directions to enable staff and others who provide direct care, to appropriately care for each resident.
2. A process to ensure that the plan of care is clearly communicated to and understood by all staff and others who provide direct care to the residents.
3. An auditing process for written plans of care that will identify problems, gaps, and indicate corrections needed to provide clear direction to staff and others who provide direct care to the residents.
4. Education and retraining for all staff involved in developing residents written plans of care, including the risks associated with the lack of clear directions to staff and others who provide direct care to the residents.
5. A multidisciplinary process to ensure clear communication between RNs, RPNs, and PSWs, so that the plans of care always provide clear directions to staff and others who provide direct care to the residents.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by September 30, 2015 with full compliance by December 2, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care that sets out clear directions to staff and others who provide direct care to resident #028.

On July 28, 2015 at 0815hrs, Inspector #603 reviewed resident #028's health care record and noted that the resident had a fall and sustained an injury. The attending physician ordered complete bed rest for one week.

On July 29, 2015, Inspector #603 reviewed resident #028's care plan. The care plan had a focus for bathing and the interventions included to give a bed bath daily and prn while on bed rest. Another focus was seen in which the interventions identified assistance for showers.

On review of the resident's health care record, Inspector #603 noted that the Dietitian ordered a specific diet and texture. The care plan had a focus on diet and were to provide a the same specific diet and texture. On review of the home's Meal Service Report, resident #028 was to receive a specific diet and a different texture. During an interview with S#143, they indicated that staff utilize this form in order to identify what kind of food is to be prepared for each meal. During an interview with S#130, they explained that the specific diet and texture information had not been communicated to the dietary department and transferred to the Meal Service Report because the orders had not been co-signed by two staff members.

On July 28, 2015 at 0840hrs, Inspector #603 observed resident sleeping in bed with side rails engaged. During an interview with S#142, they explained that resident #028's POA had requested side rails to be engaged. Inspector #603 reviewed resident #028's care plan. The care plan had a focus for bed mobility and the interventions indicated a different usage for side rails. During a discussion with S#130, they explained that all staff refer to the care plan in order to determine the required care. (603)

2. The licensee has failed to ensure that there was a written plan of care that sets out clear directions to staff and others who provide direct care to resident #018.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that on a certain date, resident #018 was unhappy with the

manner in which a staff member spoke with them and also that the care was not provided to them in a timely manner. Resident #018 explained that the staff member raised their voice when responding to their call bell. The resident stated: "They yelled at me". The resident was upset because of the lack of care. The resident then stated: "I'm so fed up with this life". According to the CI, the long-term actions to correct this situation and prevent recurrence were to update and adjust the care plan as the resident's care needs changed and staff would provide care in pairs.

Inspector reviewed the home's investigation which concluded that they were satisfied that the complaint was not as a result of S#118's actions or the actions of any employee of the home.

Inspector reviewed the progress notes from a period of 6 weeks, which indicated resident #018 displayed responsive behaviors on 8 different days during these 6 weeks.

Inspector #603 reviewed resident #018's care plan for the same period of 6 weeks. These care plans had no focus related to responsive behaviors, in fact, both care plans had a focus for mood state. However, there were no interventions to address this focus. The resident continued to have behaviors and in the latter care plan, there was no direction for staff to provide care in pairs.

Inspector #603 interviewed S#110 who explained that the probable reason for not identifying a focus related to responsible behaviors in the care plan was that the resident only displayed these behaviors when they had a specific health condition the resident periodically had. On review of the care plans, there was no focus to address a specific health condition the resident periodically had.

LTCHA, 2007 S.O. 2007, s. 6. (1) (c) was issued previously as a WN and CO during Inspection #2015_283544_0006, a WN and VPC during Inspection #2014_331595_0010, a WN during Inspection #2013_138151_0010, a WN and CO during Inspection #2013_138151_0008. (603)

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

Dec 02, 2015(A3)

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_283544_0006, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

(A3)
The licensee shall prepare, submit, and implement a plan to ensure that the resident, the resident s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident s plan of care, which includes the following:
1. A review and revision of the current process to ensure that the resident, the resident s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker participate fully in the development and implementation of the resident s plan of care.
2. An auditing process that will identify problems and gaps, and that residents and residents substitute decision-makers who should participate in the development and implementation of residents care plans, does so.
3. Education and retraining for all staff, related to the above process.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by September 30, 2015 with full compliance by December 2, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On July 21, 2015, during stage 1 of the Resident Quality Inspection, Inspector #617 conducted an interview with resident #003's family member and substitute decision maker (SDM). The family member reported that they were not notified of the medication changes that were noted on a medication list they had reviewed.

Inspector #617 reviewed resident #003's progress notes, which indicated that the physician had assessed the resident, determined there was a specific health condition, and ordered a treatment. Staff #126, who was the author of the note indicated that they would make the SDM aware of the change. Inspector #617 reviewed the physician's orders, which indicated a treatment.

On July 28, 2015 at 1024, Inspector #617 interviewed resident #003's SDM who reported that they were aware the physician was scheduled to assess the resident but were not aware of any treatment started. Inspector #617 interviewed S#126 who reported that resident #003's alternate contact was present when the physician attended and prescribed a treatment. Staff #126 confirmed that they did not directly inform the SDM of the resident's new treatment.

LTCHA, 2007 S.O. 2007, s. 6. (5) was issued previously as a WN and CO during Inspection #2015_283544_0006, a WN and CO during Inspection #2013_138151_0008, a WN and VPC during Inspection #2013_140158_0001. (617)

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

Dec 02, 2015(A3)

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

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 :

(A3)
The licensee shall prepare, submit, and implement a plan to ensure that the written policy entitled Resident Abuse - Staff to Resident #OPER-02-02-04, version November 2013, is complied with. The plan shall include the following:
1. Education during orientation and annual retraining on the home s policy on Resident Abuse - Staff to Resident #OPER-02-02-04, version November 2013, for all staff.
2. Steps the licensee will take to ensure that all staff members receive education and retraining on the home s policy on Resident Abuse - Staff to Resident #OPER-02-02-04, version November 2013 .
3. An auditing process to ensure that all staff receive education during orientation and annual retraining on the home s policy on Resident Abuse - Staff to resident which indicates there is zero tolerance of abuse toward residents.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by September 30, 2015 with full compliance by December 2, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy titled, Resident Abuse - Staff to Resident, #OPER-02-02-04, version November 2013 was complied with.

Inspector #575 reviewed two Critical Incident (CI) Reports regarding alleged staff to resident abuse. In the first CI, it was reported that S#144 failed to care for resident #024's. In the second CI, it was reported that S#145 verbally abused and neglected resident #024 by demeaning the resident.

The Inspector noted that the first CI occurred in 2014 and the second CI occurred one day later. On review of the documentation, Inspector noted that both CI's were not submitted to the Director until two or three days later. In both CI's, the staff who reported sent an email/note to the DOC, days after the incident and did not report to the nurse in charge, nor the manager on call. The home's policy outlined that if abuse was suspected or witnessed, staff are to immediately report (verbally) to the Administrator, DOC, or their designate.

As a result of the investigation for the first CI, S#144 received a letter of discipline. The Inspector noted that the home's policy indicated that abuse would result in termination and neglect could result in discipline up to and including termination; however, where an act of neglect is determined to fall within the definition of abuse (e.g., resident abuse by neglect, then the result would be termination).

In addition, the policy outlined that all staff are responsible to ensure that they understand and comply fully with the Resident Abuse - Staff to Resident policy and procedures. (575)

2. The licensee has failed to ensure that the policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

Inspector #575 reviewed a Critical Incident (CI) Report regarding alleged staff to resident abuse. The Inspector noted that as a result of the abuse investigation, S#146 was in violation of the home's policy and received a disciplinary action.

The Inspector noted that the home's policy indicated that resident abuse would result in termination. During an interview, S#110 indicated that the home had requested corporate to change the current policy to reflect what they currently do. Staff #110 explained that the home has another policy outlining progressive discipline and S#110 indicated that these policies contradict each other.

In addition, the policy outlined that annually, staff would receive education and training on the abuse policy as well as identification, prevention and reporting as part of the home's in-service training plan. The Inspector reviewed S#146's file and training records and noted that the staff member did not receive training in 2014. Staff #110 confirmed that S#146 did not receive training in 2014 as required by policy.

LTCHA, 2007 S.O. 2007, s. 20 (1) was issued previously as WN and VPC during Inspection #2015_320612_0006, a WN during Inspection #2014_331595_0010, a WN during Inspection #2013_138151_0008. (575)

3. The licensee has failed to ensure that the policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04, version November 2013 was complied with.

Inspector #575 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that according to the progress notes, resident #021 advised an RPN that they were yelled at by a staff member of the home. The RPN advised the RN of the incident and the RN identified that they would follow up with the resident, however they did not. The CI further indicated that the recorder of the progress notes did not alert management to the event and no CI was submitted. The incident was not investigated until 14 months after the incident occurred.

The Inspector reviewed the home's policy titled, 'Resident Abuse - Staff to Resident', #OPER-02-02-04 version November 2013. Under the section 'Responding/Reporting- Suspected or witnessed abuse', #3 indicated that staff are to immediately report (verbally) any suspected or witnessed abuse to the Administrator, DOC, or their designate who must report the incident as required by provincial legislation and jurisdictional requirements...'. The policy further indicated that anyone who suspects or witnesses abuse and/or neglect that causes or may cause harm to a resident is required to contact the Action Line and failure of staff to verbally report the incident to the Administrator, DOC or their designate immediately could result in disciplinary action.

In addition, the policy outlined that annually, staff would receive education and training on the abuse policy as well as identification, prevention and reporting as part of the home's in-service training plan. The Inspector reviewed the training records and S#110 confirmed that the two staff involved in the CI did not receive training in 2014, and one of the same staff had not yet received training in 2015 to date.

(575)

4. The licensee has failed to ensure that the policy titled, Resident Abuse - Staff to Resident, #OPER-02-02-04, version November 2013 was complied with.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. In 2015, the night shift RPN found resident #017 at the nursing desk, sitting in their wheelchair with two specific restraints on. The resident was having responsive behaviors and wanted to go to bed. The RPN assessed that the resident was displaying a health condition and offered the resident treatment which the resident accepted. The RPN called the RN in charge and was asked to consult on the care plan, and noted that the restraints were not an acceptable intervention, and there was no order for the restraints. On this finding, the RN instructed the RPN to immediately remove the restraints, to provide comfort measures to the resident, to assess the resident for any negative outcomes and to document the event.

Inspector #603 reviewed the home's policy on Resident Abuse - Staff to Resident, Policy Reference #OPER-02-02-02. The policy indicated there is zero tolerance of abuse toward a resident. The home is committed to providing a safe and supportive environment in which all residents are ensured dignity and respect. Abuse includes physical abuse and emotional abuse. Resident abuse will result in termination.

Inspector #603 reviewed the home's investigation reports from this CI. Staff #112 was found to be in violation of the home's policies on Least Restraint and Prevention of Resident Abuse and for this reason, S#112 received a disciplinary action. (603)

5. The licensee has failed to ensure that the policy titled, Resident Abuse - Staff to Resident, #OPER-02-02-04, version November 2013 was complied with.

On July 23, 2015, Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that a PSW working at the home reported to the RPN, that resident #019 had complained to them, that a PSW was rude to them. The CI indicated that the resident rang the bell for assistance. The resident stated that the PSW said: "You're too lazy to use the bathroom". The resident stated that this PSW had been rude on other occasions but the resident had not reported this as they were afraid of future negative interactions with this PSW.

Inspector #603 reviewed the home's policy on Resident Abuse - Staff To Resident, Policy Reference #OPER-02-02-04. The policy indicated that there is zero tolerance of abuse toward a resident. All residents are ensured dignity and respect. Resident abuse will result in termination. Abuse includes emotional abuse and verbal abuse.

The home did an investigation regarding verbal abuse and found S#111 to be in violation of Extendicare York's policies on abuse. Subsequently, S#111 received a disciplinary action. (603)

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

Dec 02, 2015(A3)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee shall ensure that all staff and others who provide direct care to residents implement policy #CLIN-05-01-02 entitled Clinical Procedures Manual regarding Care of Resident, during hot weather with regards to the following:
1. Perform a daily dry and humid air temperature reading.
2. Preventative and emergency measures for dry and humid air temperature reading thresholds to be put in place to prevent against heat related illnesses.
3. Implement preventative measures when the dry temperature is above 28 degrees Celcius. The home's preventative measures include the following:
- close the window, drapes and blinds during the day
- ensure residents are adequately hydrated
- alter meal plans to provide lighter, cool meals which contain extra fluids
- encourage loose clothing
- remove excess bedding
- reduce recreational programs
- restrict outdoor activities
- encourage residents to remain in cooler areas
4. Appropriate staff to review and sign off on an annual basis, the home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual regarding Care of Resident, during hot weather.

Grounds / Motifs :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan for the home that meets the needs of the residents was implemented when required to address the adverse effects on residents related

to heat.

On July 21, 2015, Inspector #617 conducted an interview with resident #003's family member who reported that there is no air conditioning on the unit's corridor. According to the family member, when the outside temperature reaches over 25 degrees Celsius, it's stifling in the building and resident #003 responds negatively to the heat.

Inspector #617 reviewed the home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual regarding Care of Resident during hot weather, last updated December 2002. The policy identified preventative and emergency measures for dry and humid air temperature reading thresholds to be put in place, to prevent against heat related illnesses. Staff #102 submitted to Inspector #617 a daily log sheet dated July 1 to 23, 2015, which identified daily building temperature readings for dry air only. Inspector #617 interviewed S#124 who reported that they took the recorded temperatures in the air cooled dining room from the thermostat daily, in the morning. Staff #124 reported that they do not take daily humidity readings. Staff #102 confirmed that since 2013 there has been a gap in monitoring the humidity in the home and the staff have not been monitoring the threshold according to policy, for identifying when the preventative or emergency measures are to be put in place.

The home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual for Care of Resident during hot weather, last updated on December 2002, indicated that preventive measures are to be put in place when the dry temperature is above 28 degrees Celsius. The preventative measures include the following:
- close the window, drapes and blinds during the day
- ensure residents are adequately hydrated
- alter meal plans to provide lighter, cool meals which contain extra fluids
- encourage loose clothing
- remove excess bedding
- reduce recreational programs
- restrict outdoor activities
- encourage residents to remain in cooler areas

On Jul 27, 2015 at 1414hrs, Inspector #617 measured the temperature in one specific corridor and the result was 29.1 degrees Celsius. Inspector #617 observed the following in the rooms of the same corridor:
- only three of the sixteen residents' rooms had their windows and curtains closed.

- all existing floor and table fans were on and working in the residents' rooms however not all rooms had fans
- residents were found sleeping in their beds wearing long sleeved pants and shirts and were covered with blankets.
- resident #026 was observed by Inspector #617 to be wearing a long sleeved shirt and long pants and their face was red in color. Resident #026 was walking in the hallway and demonstrating responsive behaviors. Staff #108 reported that resident #026 was having responsive behaviors on that day possibly due to the hot temperature on the unit. On July 27, 2015 at 1440hrs, Inspector #617 interviewed S#107 and S#125 who reported that they had not been notified that there was a hot weather protocol in effect. On July 27, 2015, Inspector #617 observed that the lunch served on a specific unit was hot with steam coming out of the servery. (617)

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

Sep 16, 2015

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Order / Ordre :

The licensee shall ensure that the home has at least one separate designated cooling area for every 40 residents while there is no available central air conditioning.

Grounds / Motifs :

1. The licensee has failed to ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents.

On July 21, 2015, Inspector #617 conducted an interview with resident #003's family member who reported that there is no air conditioning in the resident #003's corridor and when the outside temperature reaches over 25 degrees Celsius, it's stifling in the building and resident #003 responds negatively to the heat.

Inspector #617 toured the a specific unit and the main lobby with staff #102 who reported the following regarding air conditioning in the home:
- the home does not have centralized air conditioning
- condensers are located on the roof top which provide air conditioning by forced air through a ceiling vent to only the main floor's activity room and to each nursing station on all residential floors
- a chiller is located on the rooftop that supplies air conditioning to each dining room through 2 DX coils for all floors.
- window air conditioners are allowed in resident rooms and are supplied and maintained by residents/substitute decision makers. Staff #102 reported that the home doesn't keep a log of the units currently being used by residents.

On July 29, 2015, Inspector #617 reviewed the home's total census which identified 283 residents, presently living in the home. More specifically, there were 57 residents living on a specific unit. There was a total of 6 cooled rooms in the building (five dining rooms - one on each unit and one activity room). If all the residents were attending the six rooms there would be 47 residents in each of the cooled rooms.

On July 20, 2015 at 1730hrs, Inspector #617 inspected a meal service in a specific dining room. There were 55 of the 57 residents seated in this dining room. A thermostat was located on the pillar, in the middle of the dining room, which indicated that the temperature was just below 28 degrees Celsius.

The home's policy #CLIN-05-01-02 entitled Clinical Procedures Manual for Care of Resident during hot weather last updated on December 2002, indicated that there should be at least one cooling area on each floor of the building where residents reside. These areas should provide adequate space (e.g. 15 square feet per resident) for each resident to prevent increased heating due to overcrowding. On July 20, 2015, while observing a specific dining room service, Inspector #617 observed 55 residents seated at their tables, and there was very little room to move, in between the tables and residents. The 55 residents in the air conditioned room provided by the home for the one unit, exceeded the number of residents (40) as identified in the legislation. (617)

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

Oct 30, 2015

Order # /
Ordre no : 006

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

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 :

(A3)
The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The plan will include the following:
1. A process to ensure that the plan of care for each resident is reviewed, updated, and is provided to the resident as specified in the plan.
2. An auditing process that will serve to identify when staff are not providing care as specified in the plans and a plan for corrective action.
3. A multidisciplinary process to ensure clear communication between RNs, RPNs, and PSWs, so that the care is provided to the resident as specified in the plans.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by September 30, 2015, with full compliance by December 2, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was provided to resident #003 as specified in the plan.

Inspector #617 reviewed resident #003's health care records which indicated the resident had many diagnoses. The resident required assistance with activities of daily living. Resident #003 used a specific chair for locomotion and a specific transfer device from bed to and from wheelchair.

On two days during the inspection, Inspector #617 observed resident #003 in their room, sitting in a specific chair with a restraint on. On the second day, Inspector #617 observed again the resident #003 in the dining room with a specific restraint on.

Inspector #617 interviewed S#137 who reported that the restraint for resident #003 had not been assessed as a restraint. The restraint had not been added to the care plan and was being used as per family request. Inspector #617 interviewed S#138 who reported that the restraint was used for positioning resident #003.

Inspector #617 interviewed resident #003's family member who stated that it was the intention of the family to use the restraint when resident #003's condition worsened. The family member stated that the use of the specific restraint was no longer needed.

Inspector #617 reviewed the care plan which did not indicate the use of a specific restraint for positioning. (603)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #012 and #013 as specified in the plan.

During this inspection, Inspector #617 observed the lunch meal service on a specific floor from 1245hrs to 1400hrs. Inspector #617 observed S#107 feeding resident #012 who was specifically positioned in their chair.

Inspector #617 reviewed resident #012's care plan. The care plan indicated the resident required a specific diet and texture. The care plan did not give direction to position the resident in a specific position during meals.

During this inspection, Inspector #617 observed the lunch services on a specific unit from 1245hrs to 1400hrs. Inspector #617 observed S#108 feeding a specific diet and texture to resident #013 who was specifically positioned in their chair.

Inspector #617 reviewed resident #013's care plan, which indicated the resident required a specific diet and texture. The care plan did not give direction to place the resident in a specific position for feedings. (603)

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During this inspection, Inspector #612 observed S#141 assist resident #005 to the washroom and then leave the room and walk down the hallway. Shortly after, S#141 later returned to assist resident from the toilet.

Inspector #612 reviewed the resident's care plan and noted under the toileting focus that resident #005 cannot be left on toilet unattended.

Inspector interviewed S#141, S#109, and S#130 who confirmed that resident #005 cannot be left unattended on the toilet as indicated in the care plan.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as WN and VPC during Inspection #2014_331595_0010, a WN and CO during Inspection #2013_138151_0008, a VPC during Inspection #2013_140158_0001. (612)

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

Dec 02, 2015(A3)

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
Performance Improvement and Compliance 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
Direction de l'amélioration de la performance et de la conformité
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 22 day of October 2015 (A3)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SYLVIE LAVICTOIRE - (A3)

Service Area Office / Bureau régional de services : Sudbury