Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur 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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2015	2015_281542_0005	S-000729-15	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 Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

JENNIFER LAURICELLA (542), MARINA MOFFATT (595), MONIKA GRAY (594), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 16-20 and 23-27, 2015

The following logs were inspected concurrently with the RQI: S-000535-14, S-000573-14, S-000184-14, S-000377-14, S-000456-14, S-000633-14, S-000006-14, S-000122-14 and S-000513-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care(s) (ADOC), Registered Staff, RAI Coordinator, Maintenance Staff, Behavioural Supports Ontario Staff (BSO), Personal Support Workers (PSWs), Residents and Family Members.

The Inspectors observed the delivery of care and services to residents, completed health care record reviews, conducted a walk through of the home daily, reviewed various home policies and procedures. The inspectors also inspected issues triggered through the resident quality inspection process.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_380593_0006	543
O.Reg 79/10 s. 229. (4)	CO #001	2014_281542_0005	595

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #542 reviewed the home's policy titled, "Resident Abuse - Staff To Resident" that was provided to the inspector by the home's Administrator. The policy indicated that, "there is zero tolerance of abuse toward a resident." Inspector #542 reviewed a Critical Incident (CI) that was submitted to the Director for staff to resident abuse/neglect. The CI identified that while providing care to resident #040, S#100 was rough, did not provide appropriate personal hygiene care and that they were verbally abusive towards the resident. Inspector #542 reviewed the home's investigation file and the employee's file, which concluded that S#100 received a written warning regarding the above care issues. [s. 20. (1)]

2. Inspector #542 reviewed a CI that was submitted to the Director by the licensee detailing staff to resident abuse/neglect. The CI indicated that S#101 left resident #039 in their room without access to their call bell. Inspector #542 spoke with resident #039 who stated that S#101 left them without access to their call bell. The resident also indicated that they did not want this staff member to care for them anymore. Inspector #542 spoke with the S#101 who confirmed that they did receive discipline for leaving the resident in their room without access to the call bell. Inspector #542 reviewed S#101's employee file which concluded that the staff member received a verbal warning for resident neglect. [s. 20. (1)]

3. Inspector #542 reviewed a CI that was submitted to the Director by the licensee detailing staff to resident abuse/neglect. The CI indicated that S#102 forced resident #037 to have personal care completed and that the staff member admitted to doing so. Inspector #542 reviewed the home's investigation which concluded that resident #037 refused to have the personal care completed but S#102 forced the resident to complete the task. Inspector #542 spoke with the DOC who confirmed that S#102 received a suspension and was required to review a variety of resources on prevention of abuse. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there are reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that result in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On March 24, 2015, Inspector #542 conducted a review of an S#101's employee file. A document in the employee's file revealed that resident #041 had accused the staff member of hurting them. Inspector #542 spoke with the Assistant Director of Care who confirmed that they were aware of resident #041's allegations. The home completed an internal investigation which revealed that the resident sustained an injury and that the resident insisted that a nurse had hurt them. The allegations towards the staff member could not be substantiated. Inspector #542 interviewed the Director of Care and the Assistant Director of Care who both confirmed that this was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On March 17 and March 18, 2015, Inspector #594 observed one bed rail up on resident #002's bed. Inspector #595 spoke with DOC who stated that when bed rails are used for residents, the home does not assess the resident for the use of bed rails. She explained that the beds come with the quarter/assist rails and that they are just raised without completing an assessment. [s. 15. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives an assessment weekly using a clinically appropriate assessment instrument that is specifically designed for skin and wounds.

On March 20, 2015, Inspector #542 completed a health record review for resident #034. The most current care plan accessible to the direct care staff indicated that the resident had altered skin integrity. Inspector #542 reviewed the weekly wound assessments over a three month period from PointClickCare (PCC) and noted that there were not any assessments completed for one specific month. On March 23, 2015, Inspector #542 spoke with S#104 and S#105 who confirmed that the registered staff are to complete weekly wound assessment using the form on PCC. S#104 stated that they must have missed completing the wound assessments during that month. [s. 50. (2) (b) (iv)]

Issued on this 29th day of April, 2015

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

Original report signed by the inspector.