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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2016	2016_395613_0007	011199-16	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

LISA MOORE (613), CHAD CAMPS (609), JENNIFER LAURICELLA (542), LINDSAY DYRDA (575), MISHA BALCIUNAS (637), SHEILA CLARK (617)

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): May 2-6 and 9-13, 2016.

Additional logs inspected during this RQI include:
Seven critical incidents submitted by the home related to resident to resident abuse;
Nine critical incidents submitted by the home related to staff to resident abuse;
Four critical incidents submitted by the home related to resident falls;
One critical incident submitted by the home related to a resident hospitalization/death;
One critical incident submitted by the home related to missing resident items;
One critical incident submitted by the home related to missing narcotics;
Five complaints related to care of residents and operations of the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager (DM), Food Service Supervisor (FSS), Volunteer Coordinator, Resident Assessment Instrument (RAI) Coordinator, Support Services Manager (SSM), Registered Dietitian (RD), Nursing Clerk, Wound Care Champion Registered Nurse (WCCRN), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Dietary Aide (DA), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs), residents and family members.

During the course of the Resident Quality Inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **16 WN(s)**
- **10 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #004, #021, #022 and #023 were protected from abuse and were not neglected by the licensee or staff.

a) Inspector #609 reviewed a Critical Incident (CI) that was submitted to the Director in April 2016, which alleged PSW #108 was abusive towards resident #021 in April 2016.

A review of the home's internal investigation, of the incident confirmed there was evidence that PSW #108 abused resident #021 in April 2016, which resulted in discipline of PSW #108.

According to Long-Term Care Homes Act, 2007 O.Reg 79/10 verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

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

During an interview with PSW #109, they confirmed to the Inspector they were present and worked in April 2016, and heard PSW #108 say to resident #021 that "they didn't know what abuse was", when the resident verbalized how rough PSW #108 was with them. PSW #109 further described how resident #021 later in the evening reported to them a second time about the rough treatment they received from PSW #108, but they did not immediately report the incident because they were "so busy" and "didn't think it was abuse".

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting," last revised April 2016 indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The policy also indicated that Extendicare has a zero tolerance for abuse. Any form of abuse by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated.

The Inspector reviewed the home's policy with PSW #109 who confirmed that it was the expectation to have immediately reported the incident and that this did not occur.

b) A second CI was submitted to the Director in April 2016, which alleged PSW #108 was abusive towards resident #022 in April 2016.

During an interview with RPN #107, they confirmed to the Inspector that they were present and worked in April 2016, when they heard a loud bang from a kitchen cart pushed by PSW #108 as it struck the wheelchair of resident #022. PSW #108 then proceeded to verbally abuse resident #022. RPN #107 stated that they did not immediately report the abuse inflicted on resident #022 by PSW #108 because "we are all adults here".

RPN #107 confirmed that they did not immediately report the incident that occurred in April 2016.

c) A review of the employee file of PSW #108 revealed an incident of abuse directed towards resident #023 which occurred in March 2014.

A review of the home's internal investigation of the incident in March 2014, revealed that PSW #108 used demeaning language when they spoke to resident #023, unsafely transferred the resident which caused the resident to call out in pain and was disrespectful towards the family of resident #023 when they verbalized their care concerns to PSW #108 during the incident.

Section 24 (1) of the LTCHA says that a person who has reasonable grounds to suspect that 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 has occurred is to immediately reported the suspicion and the information upon which it was based to the Director. [s. 19. (1)]

2. Inspector #542 reviewed a CI that was submitted to the Director in January 2016, regarding alleged staff to resident abuse. The CI indicated that resident #004 had reported to RPN #144 that a staff member was abusive towards them.

The Inspector reviewed the home's investigation file of the alleged abuse. Through the home's investigation, they concluded that PSW #141 refused to provide a specific care need to resident #004. PSW #141 received discipline.

The Inspector reviewed PSW #141's employee file. It was documented in their employee file in April 2015, that PSW #141 failed to provide another resident with a specific care need and informed the resident to not ring their call bell again. In addition, the Inspector noted that PSW #141 received discipline for a specific abuse of another resident in February 2016.

S. 23 (1) of the LTCHA states that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, appropriate action is taken in response to every such incident and any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

During an interview with the Assistant Director of Care, they confirmed that the home did not complete an investigation as required by the legislation for the incident in April 2015.

Management of the home was aware that PSW #141 was involved in three incidents of resident abuse that occurred in April 2015, January 2016 and February 2016, PSW #141 continued to provide care to residents despite abusive conduct. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care that set out the planned care for resident #011.

During stage 1 of the RQI, resident #011 was observed to be incontinent of urine.

During an interview, with PSW # 110, they reported to Inspector #575 that the resident

was incontinent, required the use of continence care products and the assistance of staff for continence care.

The Inspector reviewed the resident's plan of care regarding bowel incontinence. Under the focus, "bowel care", last revised December 2015, the plan of care indicated that the resident was occasionally incontinent of bowels and interventions identified that the resident toileted themselves and was totally incontinent of bowels. The resident's bowel continence assessment dated December 2015, indicated that the resident was incontinent.

The Inspector reviewed the plan of care with RPN #111. The RPN confirmed that the resident's continence care product was changed while the resident was in bed and the resident did not toilet themself. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to resident #015 and #005.

According to a CI submitted to the Director, in August 2015, resident #015 had a fall and sustained an injury.

Inspector #575 reviewed the resident's plan of care. Under the "transfer" focus, interventions stated that staff were to position a four wheeled walker or wheelchair to facilitate resident use. The "walk in room" and "falls" focuses indicated that the resident walked short distances using the four wheeled walker with staff's assistance, however, under "physiotherapy"' interventions indicated that the resident used a two wheeled walker.

The Inspector observed a wheelchair and two wheeled walker in the resident's room.

During an interview with RPN #100, they stated that the resident usually used a wheelchair and would walk with physiotherapy staff using a two wheeled walker. The RPN confirmed that the resident did not use a four wheeled walker.

During an interview with the Assistant Director of Care (ADOC), they determined that the four wheeled walker was an auto-populated intervention; however, staff should have edited the intervention to reflect the use of the two wheeled walker. The ADOC confirmed that the plan of care did not provide clear directions. [s. 6. (1) (c)]

3. Inspector #542 completed a health care record review for resident #005. It was documented in the progress notes that resident #005 had an urinary intervention. The resident was observed by the Inspector to have an urinary intervention. The most current care plan that was on the unit for the direct care staff did not include any information about the urinary intervention.

During an interview with RPN #116, they confirmed that resident #005 did have a urinary intervention and that the plan of care should have been revised to include the urinary intervention. [s. 6. (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 to ensure that there is a written plan of care that sets out the planned care for resident #011 and that the plan of care sets out clear directions to staff and others who provided direct care to resident #015 and #005, to be implemented voluntarily.

WN #3: 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 written policy in place to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting," last revised on April 2016 indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of

abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The policy also indicated that Extendicare has a zero tolerance for abuse. Any form of abuse by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated.

Inspector #617 reviewed a CI that was submitted to the Director in March 2016, regarding staff to resident abuse. The incident occurred in March 2016, and the staff member who witnessed the incident reported it to the home, two days after the incident occurred.

A review of the home's investigation into the incident indicated that PSW #140 witnessed PSW #139 rough handle resident #029 during the provision of care. Resident #029 then displayed a specific responsive behavour and PSW #139 was rough during care with resident #029 causing discomfort. The home's investigation concluded that PSW #139 had been rough during care with resident #029 in April 2016 and was disciplined.

A review of the home's documentation into the incident indicated that PSW #140 did not report the incident immediately to the appropriate person as they were afraid of retaliation from PSW #139.

During an interview on May 10, 2016 with the Director of Care (DOC), they confirmed that PSW #140 did not report the incident immediately to the Registered Staff as indicated in the home's policy. As well, PSW #139 did not follow the home's policy while providing care to resident #029.

2. Inspector #609 reviewed a CI that was submitted to the Director in April 2016, which alleged PSW #108 was abusive towards resident #021 in April 2016.

a) A review of the home's internal investigation, of the incident confirmed there was evidence that PSW #108 abused resident #021 in April 2016, which resulted in discipline of PSW #108.

During an interview with PSW #109, they confirmed to the Inspector they were present and worked in April 2016, and heard PSW #108 say to resident #021 that "they didn't know what abuse was", when the resident verbalized how rough PSW was with them. PSW #109 further described how resident #021 later in the evening reported to them a second time about the rough treatment they received from PSW #108, but they did not

immediately report the incident because they were "so busy" and "didn't think it was abuse".

The Inspector reviewed the home's policy with PSW #109 who confirmed that it was the expectation to have immediately reported the incident and that this did not occur.

b) A second CI was submitted to the Director in April 2016, which alleged PSW #108 was abusive towards resident #022 in April 2016.

During an interview with RPN #107, they confirmed to the Inspector that they were present and worked in April 2016, when they heard a loud bang from a kitchen cart pushed by PSW #108 as it struck the wheelchair of resident #022. PSW #108 then proceeded to verbally abuse resident #022. RPN #107 stated that they did not immediately report the abuse inflicted on resident #022 by PSW #108 because "we are all adults here".

RPN #107 confirmed that they did not immediately report the incident that occurred in April 2016. [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 written policy in place to promote zero tolerance of abuse and neglect of residents is complied with., to be implemented voluntarily.

WN #4: 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 had failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident occurred or may occur by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed a CI submitted to the Director in December 2015. The CI identified that from May 2015 until December 2015, there were several reported instances of missing resident items, including money. The police were notified of all residents' missing money and items in April 2015 when it was suspected by the licensee that theft had occurred and in December 2015, they arrested an employee of the home.

According the the LTCHA, financial abuse is defined as any misappropriation or misuse of a resident's money or property.

The Inspector reviewed the home's internal investigation file that identified a total of 26 reported occurrences of residents' missing money, involving several residents, from January 2015 to December 2015. Management was aware of all reported occurrences dating back to January 2015 and conducted an internal investigation for each occurrence; however, they did not report each occurrence of suspected financial abuse to the Director.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting," last revised on April 2016 indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. In addition, anyone who suspects or witnesses abuse, under the LTCHA is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line.

During an interview on May 13, 2016, the Administrator confirmed that each occurrence of resident missing money should have been reported to the Director as the home had a suspicion that theft had occurred. [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 abuse of a resident occurred or may occur by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for the methods to reduce risk and monitor outcomes, including protocols for the referrals of residents to specialized resources where required.

Inspector #575 conducted health care record reviews and determined that resident #008 and #011 had altered skin integrity. The Inspector reviewed the weekly skin assessments on a form titled, "Skin - Weekly Wound Assessment - includes Bates-Jensen - V 5 Complete Weekly Wound Reassessment", for both residents for a period of approximately one month and noted that some assessments were not fully completed:

For resident #008:
Two occasions - "Skin - Weekly Wound Assessment - includes Bates-Jensen - V 5 Complete Weekly Wound Reassessment", missing completion of questions #3, 10, 11, 12, 13;

For resident #011:
Two occasions - "Skin - Weekly Wound Assessment - includes Bates-Jensen - V 5 Complete Weekly Wound Reassessment", missing completion of questions #11, 12, 13.

During an interview with RPN #114, they stated that registered staff answer the majority of the questions on the weekly skin assessment; however, staff did not have the knowledge to answer questions #10, 11 and 13.

During an interview with RPN #121, they stated that staff should be answering all the questions on the weekly wound assessment; however, the current weekly wound assessment tool was introduced in 2015 and staff had not been trained how to properly complete the assessment.

During an interview with the Wound Care Champion (WCCRN #122), they stated that at some point last year, a new weekly wound assessment was introduced; however, no education or direction was provided on how to complete it. The WCCRN #122 stated they were provided direction from the Assistant Director of Care (ADOC) to figure out a way for staff to complete the assessments consistently; the WCCRN #122 then directed staff to not complete questions #3, 10, 11, 12, and 13 as these questions required additional knowledge and skills to complete.

Inspector #575 reviewed the home's current policies titled, "Pressure Ulcers #03-07" and "Wound Care Record #03-09", last revised on June 2010. These policies indicated that staff were to document the weekly wound assessment on the wound care record in the policy and all areas of the form were to be completed; however, the " Wound Care Record" was not the current assessment form used by staff.

During an interview with the ADOC, they confirmed that a new assessment tool was launched in Spring 2015; however, the current policy did not include this assessment tool. The ADOC indicated that a new program/policy was planned to be launched in June 2016, which included the new assessment tool. [s. 30. (1) 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 Skin and Wound program includes a written description of its goals and objectives, relevant policies, procedures, protocols, methods to reduce risk, methods to monitor outcomes and protocols for referral of resident to specialized resources where required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #028 who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A complaint was submitted to the Director regarding resident #028 who was not assisted to the toilet when requested by the resident during the evening shifts on one occasion in March 2015 and two occasions in April 2015.

During an interview with the complainant, they indicated that in March 2015, resident #028 rang the call bell for help two times and a PSW told the resident to urinate in their brief; in April 2015, resident #028 rang the call bell for assistance to go the bathroom three times and the PSW stated they had a sore back and did not provide assistance; and in April 2015 resident #028 rang the call bell to be toileted and the PSW told the resident to go in their pants because they were short staffed.

A review of resident #028's Resident Assessment Instrument-Minimum Data Set (RAI MDS) dated January 20, 2015, indicated that they were not cognitively impaired, continent of bowel and usually continent of bladder, and used pads or briefs. A review of resident #028's bladder continence assessment completed in April 2015, indicated that the resident was continent of urine both day and night. There was no change in resident #028's continence assessment for that time period.

A review of resident #028's care plan that was in effect at the time of the occurrences, indicated that the resident was to be toileted after all meals and in the evening and used a device during the night to maintain continence. Resident #028 required the assistance of two staff to and from the toilet and wheelchair.

During an interview with resident #028, they confirmed that in March 2015, April 2015, and April 2016, they did use the call bell to request assistance to the toilet; however, the staff refused to help. As a result, resident #028 was incontinent of urine. Resident #028 reported that they were continent of urine only if the staff assisted them to get to the washroom as they were unable to get there independently.

During an interview with PSW #138, they reported that resident #028 was routinely toileted after breakfast and before bed in the evening with the assistance of staff; and resident #028's family member assisted the resident to the toilet after lunch. Both resident #028 and PSW #138 reported that the resident used the device at night to maintain continence.

A review of resident #028's "PSW Daily Care Flow Sheet Documentation", indicated that the resident was provided assistance to the toilet once on each day shift, once on each

evening shift and offered a device three times each night shift, for a specific time period, dated May 2016. [s. 51. (2) (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 to ensure that resident #028 who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration program included the implementation, in consultation with a Registered Dietitian who was a

member of the staff of the home, policies and procedures related to nutrition and dietary services and hydration.

Inspector #575 reviewed a complaint submitted to the Director by a family member of resident #033. During an interview with the family member, they stated concerns regarding food quality: vegetables and fruit were too hard, bread was stale, and the meat was sometimes too fatty and hard to chew.

During an interview with resident #033, they stated that the vegetables and fruit were too hard and they were not able to pierce them with their fork and the chicken and turkey had too much fat on them.

The Inspector reviewed the resident's plan of care. Under the focus related to chewing, last revised September 2015, there were interventions in the care plan that revealed the resident required a specific diet and texture. A physician order dated May 2014, stated a specific diet and texture. The resident's RAP assessment dated March 2016, indicated that the resident received a specific diet and texture due to a nutritional care concern. The diet type sheet located in the servery and on the snack carts indicated that the resident required a specific diet and a different texture.

During an interview with Dietary Aide #120, they stated that resident #033 required a specific textured diet and that the resident did not have any nutritional care concerns.

During an interview with the Registered Dietitian (RD) #128, they confirmed that the resident was ordered a specific diet texture, and according to the most recent assessment, the diet type sheet was not correct. RD #128 reported that they spoke with resident #033 who advised them that they were once on a specific diet; however, at some point they asked to be changed to a different specific texture. RD #128 explained that typically, when a resident's diet was required to be changed, staff were to complete a referral to the RD for an assessment, the RD would write a new diet order, and a communication form would be sent to the dietary staff to update the resident's dietary profile. The RD #128 confirmed that there was no documentation identifying when the resident's diet texture had changed.

During an interview with the Dietary Manager #115, they confirmed that there was no communication form completed for the diet texture change and they were unsure when the change occurred.

The home's Nutrition and Hydration policies titled, "Communication Process", "Managing Nutritional Information" and "Registered Dietitian - Dietary Department Communication and Referral", last revised September 2015 and April 2016 respectively, indicated the following: the communication form was to be used to alert the dietary department of any nutritional care changes for a resident, including diet texture; the communication form was to be used to communicate with the RD; documentation was to be updated as soon as notification was provided by the RD; registered staff were to refer to the RD for additional assessment and strategies when necessary using the referral form; resident nutritional information was to be kept current and consistent with all reference information documented in the resident's care plan. [s. 68. (2) (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 to ensure that the nutrition care and hydration program, policies and procedures relating to nutrition and dietary services and hydration are implemented, specifically regarding the communication of diet changes for resident #033, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Inspector #575 reviewed a complaint submitted to the Director by a family member of resident #033 regarding food production and food quality. During an interview with the family member, they reported there were times that the home ran out of food and that residents were not always provided their choice of meal.

During an interview with the Dietary Manager, they referred to the the home's production sheets as, "over/under sheets".

The Inspector reviewed the over/under sheets for each home area and meal service, from May 2 – 8, 2016. The sheets did not identify a title. The Inspector noted the home was short of food the following days:

May 2, 2016
- 3rd floor, short two servings of pureed cream corn at dinner

May 3, 2016
- 2nd floor, short three servings of banana halves at breakfast, short six egg salad on croissant at lunch
- 3rd floor, short four servings of pureed vegetable soup and two pureed pork roast on wheat bread at lunch

May 4, 2016
- 1st floor, short four servings of veal at dinner
- 2nd floor, short one serving raspberry gelatin at lunch and one pureed veal at dinner
- 4th floor, short six servings of barbeque chicken and three pureed barbeque chicken at dinner

May 5, 2016
- 2nd floor, short two servings pureed roast pork at dinner

May 6, 2016
- 2nd floor, short one serving of minced stewed tomatoes at lunch, one greek style chicken breast and two pureed honey mustard baked fish at dinner

May 7, 2016
- 2nd floor, short one serving of pureed banana half and one pureed warm wheat bread at breakfast, five delicatessen meat sandwiches and two minced ceasar salads at lunch, and four turkey schnitzels at dinner

May 8, 2016
- 3rd floor, short one serving of regular and pureed scrambled eggs, two bacon, and two pureed warm wheat bread at breakfast, three minced country sausage, two pureed pancakes, three minced and pureed stewed strawberries and rhubarb at lunch

May 8, 2016
- 4th floor, short two servings of minced country sausage at lunch

During an interview on May 11, 2016 with the Dietary Manager #115 and Food Service Supervisor #144, they confirmed the planned menu shortages identified by the Inspector, and that on several occasions residents were not provided their choice of meal. [s. 71. (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 to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #9: 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 May 4, 2016, Inspector #575 observed the medication storage area on one of the units with RPN #100. The RPN stated that the following week's supply of controlled substances were single-locked in the stationary cupboard in the medication room and were to be transferred into the medication cart in the evening. The Inspector observed the stationary cupboard was single-locked.

During an interview with the Assistant Director of Care (ADOC), they confirmed that the controlled substances that were stored in the stationary cupboard within the medication room were not double-locked. [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 to ensure 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 #10: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that prior to discharging resident #020 from the home, that alternatives to discharge were considered and, where appropriate, tried.

A complaint was submitted to the Director indicating that resident #020 was discharged from the home and that the licensee failed to meet the legislated requirements for discharge. The complainant stated that the resident was transferred to the hospital in March 2015, and discharged from the home that same day.

Inspector #542 completed a review of resident #020's closed health care record. The progress notes indicated that resident #020 was transferred to the hospital in March 2015. A physician's ordered dated March 2015, revealed that resident #020 was discharged from the home.

During an interview with the ADOC, they indicated that the home did not consider any alternatives to discharge prior to the actual discharge of resident #020 from the home in March 2015.

In an interview with the Administrator, they confirmed that no alternatives to discharge were considered and where appropriate tried, prior to the discharge of resident #020. [s. 148. (2) (a)]

2. The licensee has failed to ensure that prior to discharging resident #020 from the home, that they collaborated with the appropriate placement co-ordinator and other health service organizations, to make alternative arrangements for the accommodation, care and secure environment required by the resident.

A complaint was submitted to the Director indicating that resident #020 was discharged from the home and that the licensee failed to meet the legislated requirements for discharge. The complainant stated that resident was transferred to the hospital in March 2015, and then discharged from the home that same day.

Inspector #542 completed a review of resident #020's closed health care record. The progress notes indicated that resident #020 was transferred to the hospital in March 2015. A physician's ordered dated March 2015, revealed that resident #020 was discharged from the home.

During an interview with the ADOC, they confirmed that the home did not collaborate with a placement co-ordinator or any other health service organizations prior to the discharge of resident #020, they were transferred to the hospital in March 2015, and discharged from the home that same day.

During an interview with the Administrator, they confirmed that the home failed to collaborate with the placement co-ordinator and any other health service organizations prior to the discharge of resident #020. [s. 148. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that prior to discharging residents from the home, that alternatives to discharge are considered and, where appropriate, tried. As well, to ensure that the home collaborates with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident, to be implemented voluntarily.

WN #11: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training on skin and wound care.

Inspector #575 conducted a record review and determined that residents #008 and #011 had altered skin integrity. The Inspector reviewed the weekly skin assessments for both residents for a period of approximately one month and noted that some assessments were not fully completed.

For resident #008:
Two occasions - "Skin - Weekly Wound Assessment - includes Bates-Jensen - V 5 Complete Weekly Wound Reassessment", missing completion of questions #3, 10, 11, 12, 13;

For resident #011:

Two occasions -"Skin - Weekly Wound Assessment - includes Bates-Jensen - V 5 Complete Weekly Wound Reassessment", missing completion of questions #11, 12, 13.

During an interview with RPN #114, they stated that Registered staff answer the majority of the questions on the weekly skin assessment; however, staff did not have the knowledge to answer questions #10, 11 and 13.

During an interview with RPN #121, they stated that staff should answer all the questions on the weekly wound assessment; however, the current weekly wound assessment tool was introduced in 2015 and staff have not been trained how to properly complete this assessment.

During an interview with the Wound Care Champion (WCCRN #122), they stated that at some point last year, a new weekly wound assessment was introduced, however, no education or direction was provided on how to complete them. The WCCRN #122 stated they were provided direction from the ADOC to figure out a way for staff to complete the assessments consistently; the WCCRN #122 then directed staff to not complete questions #3, 10, 11, 12, and 13 as these questions required additional knowledge and skills to complete. The WCCRN #122 stated that they had completed one to one training with Registered staff regarding the new assessment, however, day and night staff had not received any one to one training. The WCC RN #122 confirmed they did not have a record of the training completed.

During an interview with the ADOC, they confirmed that a new assessment tool was launched in Spring 2015, however, the current policy did not include this assessment tool. The Inspector requested the training records for 2015 skin and wound care; the ADOC stated that the skin and wound care training consisted of the following:

-Read and sign - general skin care for all staff
-Smith and Nephew Global Wound Academy online module and exam for Registered staff
-One to one with the Wound Care Champion RN for Registered staff

The Inspector reviewed the training records and noted that all direct care staff did not complete the training:

-Read and sign - general skin care for all staff: 91/160 PSWs, 24/46 RPNs, and 10/20 RNs did not complete

-Smith and Nephew Global Wound Academy online module and exam for Registered staff: 4 RNs and 12 RPNs did not complete
-No records for one to one with the WCCRN for the Registered staff

During an interview with the ADOC, they confirmed that all direct care staff did not complete the skin and wound care training as required in O. Reg. s. 221(1) 2. [s. 221. (1) 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 to ensure that direct care staff are provided training on skin and wound care as required, to be implemented voluntarily.

WN #12: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #575 reviewed a CI report submitted to the Director in February 2016 regarding a controlled substance missing/unaccounted. The CI indicated that during the 0700 hours count in February 2016, it was discovered that a controlled substance was missing. The home's investigation revealed that one RPN did not complete the count upon starting or leaving their 1500 - 2300 hours shift.

A review of the home's policy titled, "Shift Change Monitored Drug Count", last revised on January 2014, revealed that two registered staff (leaving and arriving) together shall count the actual quantity of medications remaining, record the date, time, quantity of medication and sign the appropriate spaces on the shift change monitored medication count form, and confirm the actual quantity was the same as the amount recorded on the individual monitored medication record.

During an interview with the ADOC, they confirmed that one RPN did not complete the count upon arriving or leaving their shift as required. [s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of their investigation and actions taken in response to the incident that occurred between resident #024 and resident #025 that occurred in August 2014.

Inspector #613 reviewed a CI that was submitted to the Director in August 2014. The CI identified that resident #025 was wandering into resident rooms. Resident #025 wandered into resident #024's room and resident #024 told resident #025 to get out of their room. A confrontation occurred in the hallway between the two residents and resident #024 injured resident #025.

In August 2014, the Director had requested that the CI be amended for further information. The Inspector was unable to locate an amended CI report.

During an interview on May 13, 2016 with the Administrator, they confirmed that the CI had not been amended to indicate the further required information as requested by the Director. [s. 23. (2)]

WN #14: 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, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations of each of the home's eight tub rooms were conducted on May 6, 2016, which revealed four or 50 per cent had unattended unlabelled personal items. These unlabelled personal items included but were not limited to used bars of soap and used hairbrushes with hair noted on them.

During an interview with the ADOC, they confirmed that it was the expectation of the home that personal items, including personal aids such as dentures, glasses and hearing aids were labelled within 48 hours of admission and of acquiring, in the case of new items.

The ADOC confirmed that in regards to the unlabelled personal items found in 50 per cent of the home's tub rooms, the home was not in compliance with the Regulation and should have been. [s. 37. (1) (a)]

WN #15: 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,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, the equipment, supplies, devices and positioning aids referred to in subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A complaint was submitted to the Director that the home had run out of barrier cream for the month of April 2016 that was used to prevent skin breakdown for resident #027's specific care.

A review of resident #027's Resident Assessment Instrument Minimal Data Set (RAI MDS) dated March 2016, indicated that ointment was applied to the resident's skin. The RAI MDS did not indicate use of barrier cream. Resident #027's care plan revised in December 2015 did not indicate resident received barrier cream to the skin.

During an interview with resident #027's family member, they explained that barrier cream was used for the resident to prevent skin breakdown for a specific care need. Resident #027's family member reported that the barrier cream was not available to apply to the resident during the month of April; therefore, they purchased the cream for the home to use on resident #027.

During an interview with PSW #137, they confirmed that as part of resident #027's specific care need, barrier cream was used to prevent skin breakdown.

During an interview with RPN #105 and RPN #135 and with PSW #137, they reported that the home had been short of barrier cream over the month of March and April. Residents who ran out of barrier cream did not have replacements.

During an interview with Nursing Clerk #136, who was responsible for ordering the barrier cream through the Ministry of Health (MOH) requisition for Ontario Disability Benefits, they reported that in March 2016, they submitted an order for the barrier cream, and April 2016, the request for the order was sent back denied. Nursing Clerk #136 reported that they did not let the Director of Care (DOC) know about the denied order.

During an interview with the DOC, they confirmed that they were not aware the home was denied the order placed to the MOH for the barrier cream, and confirmed that the home was short of the barrier cream used for residents who were incontinent to prevent skin breakdown. [s. 50. (2) (c)]

WN #16: 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 resident #005's substitute decision-maker, if any, and any other person specified by the resident, was notified immediately upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health and well-being.

Inspector #617 reviewed a CI that was submitted by the home to the Director in February 2016, regarding staff to resident abuse. A review of the CI indicated that resident #043 reported to the staff concerns of the way their roommate, resident #005 was treated by PSW #141 during the night shift.

A review of the home's investigation into the incident concluded in February 2016, that PSW #141 abused resident #005. A review of the home's investigation notes, CI report

and resident #005's progress notes did not indicate that the substitute decision maker (SDM) was made aware of the incident and the home's investigation.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01", last revised on April 2016, indicated that disclosure of the alleged abuse will be made to the resident/substitute decision-maker (SDM) /power of attorney (POA), immediately upon becoming aware of the incident, unless the SDM/POA was the alleged perpetrator.

During an interview on May 12, 2016 with the Director of Care (DOC), they confirmed that resident #005's SDM was not notified immediately of the incident. [s. 97. (1) (a)]

2. The licensee has failed to ensure that resident #040's substitute decision-maker (SDM) were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Inspector #617 reviewed a CI that was submitted by the home to the Director regarding staff to resident abuse. A review of the CI indicated that in February 2016, resident #040's family member and SDM reported to the Assistant Director of Care #142, that PSW #143 rough handled resident #040 during a transfer which caused the resident to sustain an injury.

A review of the home's documentation indicated that they conducted an investigation and in February 2016, concluded that PSW #143 did not abuse resident #040 during the provision of care.

During an interview on May 12, 2016 with the Director of Care (DOC), they confirmed that resident #040's SDM was not notified of the outcome of the home's investigation into the incident that they brought forward. [s. 97. (2)]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), CHAD CAMPS (609), JENNIFER LAURICELLA (542), LINDSAY DYRDA (575), MISHA BALCIUNAS (637), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_395613_0007
Log No. / Registre no:	011199-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 14, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Johanne Messier-Mann

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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan, ensuring that all residents are protected from abuse by anyone and not neglected by the licensee or staff.

The plan shall include the following:

- a detailed description of what steps the home will take to ensure that all residents are protected from abuse by anyone and shall ensure that all residents are not neglected by the licensee or staff.

-how the home will ensure the "Zero Tolerance of Resident Abuse and Neglect Program" including related and supplemental policies and procedures are followed by all staff when an alleged, suspected or witnessed incident of resident abuse or neglect occurs, through development of a check list or tracking system.

- how the home will ensure that management or designated staff who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.

- how the home will ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee, is immediately investigated.

The plan shall also include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation.

This plan shall be submitted, in writing, to Lisa Moore, Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at lisa.moore2@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133. This plan must be received by September 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #004, #021, #022 and #023 were protected from abuse and were not neglected by the licensee or staff.

a) Inspector #609 reviewed a Critical Incident (CI) that was submitted to the Director in April 2016, which alleged PSW #108 was abusive towards resident #021 in April 2016.

A review of the home's internal investigation, of the incident confirmed there was evidence that PSW #108 abused resident #021 in April 2016, which resulted in discipline of PSW #108.

According to Long-Term Care Homes Act, 2007 O.Reg 79/10 verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

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

During an interview with PSW #109, they confirmed to the Inspector they were present and worked in April 2016, and heard PSW #108 say to resident #021 that "they didn't know what abuse was", when the resident verbalized how rough PSW #108 was with them. PSW #109 further described how resident #021 later in the evening reported to them a second time about the rough treatment they received from PSW #108, but they did not immediately report the incident because they were "so busy" and "didn't think it was abuse".

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting," last revised April 2016 indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The policy also indicated that Extendicare has a zero tolerance for abuse. Any form of abuse by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated.

The Inspector reviewed the home's policy with PSW #109 who confirmed that it was the expectation to have immediately reported the incident and that this did not occur.

b) A second CI was submitted to the Director in April 2016, which alleged PSW #108 was abusive towards resident #022 in April 2016.

During an interview with RPN #107, they confirmed to the Inspector that they were present and worked in April 2016, when they heard a loud bang from a kitchen cart pushed by PSW #108 as it struck the wheelchair of resident #022. PSW #108 then proceeded to abuse resident #022 by telling them to "lose weight". RPN #107 stated that they did not immediately report the abuse inflicted on resident #022 by PSW #108 because "we are all adults here".

RPN #107 confirmed that they did not immediately report the incident that occurred in April 2016.

c) A review of the employee file of PSW #108 revealed an incident of abuse directed towards resident #023 which occurred in March 2014.

A review of the home's internal investigation of the incident in March 2014, revealed that PSW #108 used demeaning language when they spoke to resident #023, unsafely transferred the resident which caused the resident to call out in pain and was disrespectful towards the family of resident #023 when they verbalized their care concerns to PSW #108 during the incident.

Section 24 (1) of the LTCHA says that a person who has reasonable grounds to suspect that 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 has occurred is to immediately reported the suspicion and the information upon which it was based to the Director. (613)

2. Inspector #542 reviewed a CI that was submitted to the Director in January 2016, regarding alleged staff to resident abuse. The CI indicated that resident #004 had reported to RPN #144 that a staff member was abusive towards them.

The Inspector reviewed the home's investigation file of the alleged abuse. Through the home's investigation, they concluded that PSW #141 refused to provide a specific care need to resident #004. PSW #141 received discipline.

The Inspector reviewed PSW #141's employee file. It was documented in their employee file in April 2015, that PSW #141 failed to provide another resident with a specific care need and informed the resident to not ring their call bell

again. In addition, the Inspector noted that PSW #141 received discipline for a specific abuse of another resident in February 2016.

S. 23 (1) of the LTCHA states that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, appropriate action is taken in response to every such incident and any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

During an interview with the Assistant Director of Care, they confirmed that the home did not complete an investigation as required by the legislation for the incident in April 2015.

Management of the home was aware that PSW #141 was involved in three incidents of resident abuse that occurred on April, 14, 2015, January 13, 2016 and February 17, 2016, PSW #141 continued to provide care to residents despite abusive conduct.

The scope of this issue was a pattern of staff not protecting the residents from abuse or neglect by not immediately reporting an alleged, suspected or witnessed resident incident of abuse or neglect. The severity was determined to be actual harm/risk of the residents of the home. There was a previous compliance order issued on October 3, 2014, related to this during 2014_380593_006 inspection.
(613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 14th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

Service Area Office /
Bureau régional de services : Sudbury Service Area Office