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
Oct 5, 2016	2016_395613_0014	014537-16, 015060-16, 015947-16, 016025-16, 016235-16, 017415-16, 017627-16, 018115-16, 019577-16, 020355-16, 021125-16, 021330-16, 021706-16, 021965-16, 022406-16, 022510-16, 022714-16, 023368-16, 023869-16, 023940-16	Critical Incident System

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), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 8 - 12 and 15 - 17, 2016

Logs inspected during this Critical Incident System Inspection include:
Seven critical incidents submitted by the home related to staff to resident abuse;
Three critical incidents submitted by the home related to bruising of unknown origin;
Three critical incidents submitted by the home related to resident to resident abuse;
Two critical incidents submitted by the home related to resident falls resulting in an injury;
Two critical incidents submitted by the home related to resident injuries of unknown origin;
Two critical incidents submitted by the home related to missing/unaccounted controlled substances;
Two critical incidents submitted by the home related to concerns regarding care provisions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Support Services Manager (SSM), Resident Assessment Instrument Coordinator (RAI Coordinator), Registered Nurses (RN & RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Dietary Aides (DA) residents and family members.

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

A concurrent Complaint Inspection #2016_395613_0013 was also conducted during this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 the required policy for medication management system, reg. 79/10, s. 114 (2) was complied with.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director in March 2016 regarding a controlled substance missing/unaccounted for resident #013. The CI report indicated that in March 2016, it was discovered that a controlled substance was missing for resident #013.

The Inspector reviewed the home's internal investigation file that only contained the CI report submitted to the Director. There was no documentation to indicate that the home had conducted an internal investigation to locate the missing controlled substance.

A review of the home's policy titled, "Narcotics and Controlled Drugs" last revised on December 2011, stated that the Director of Care would notify the Administrator and initiate an investigation into any missing controlled substance.

Inspector #613 interviewed the Assistant Director Of Care (ADOC), who reported that this incident was reported to a former ADOC #125 that no longer was employed with the home. The ADOC was unable to locate any paper or electronic notes from the former ADOC #125 to indicate that an investigation into the missing/unaccounted controlled substance had occurred.

Inspector #613 interviewed the Director of Care (DOC), who stated that this incident should have been investigated as per the home's policy as it was their expectation.

2. Inspector #613 reviewed a Critical Incident (CI) that was submitted to the Director in July 2016 regarding missing/unaccounted controlled substances. The CI indicated that in July 2016, the Pharmacy Consultant from Medical Pharmacies was at the home conducting an audit of the medication system and discovered that the Emergency Starter Box count for a controlled substance had 7 vials missing and another controlled substance had 1 vial missing. As well, the controlled substances were not signed as being removed from the Emergency Starter Box (ESB) by the registered staff on the home's form titled, "Emergency Starter Box Drug Record Book Sheet".

The Inspector reviewed the home's internal investigation file that indicated that through their investigation that all missing/unaccounted for narcotic vials were located. The

registered staff had not completed the Emergency Starter Box Drug Record Sheet when removing the narcotic vials from the Emergency Starter Box.

A review of the home's policy titled, "Emergency Starter Box" last revised on January 2014, revealed that the Emergency Starter Box Drug Record Book Sheet was to be used by the registered staff to document all medications removed from the Emergency Starter Box and to document starter-pack replacement.

During an interview with the ADOC, they confirmed that registered staff did not follow the home's policy.

During an inspection, RPN #123 showed the Inspector the medication room where the emergency starter box is located containing the narcotic vials. The Inspector noted two forms titled, "A Quick Reference Guide for Use of ESB and Use of ESB for Individual Monitored Medication Sheets," that were taped to the inside of the double locked cupboard. RPN # 123 confirmed these sheet were for registered staff to use as a reference when removing the controlled substances from the ESB.

On August 15, 2016, Inspector #613 interviewed the Administrator, they confirmed it was their expectation that registered staff follow the home's policy when removing controlled substances form the Emergency Starter Box. [s. 8. (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 the required policy for medication management system is complied with conducting an investigation for all missing/unaccounted controlled substances and retraining registered staff on the Emergency Starter Box policy and procedure, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #613 reviewed a Critical Incident (CI) that was reported to the Director via the Action Line in June 2016, regarding the alleged staff to resident abuse by PSW #127 to resident # 016. The CI report identified that in June 2016 in a dining room located on a unit, that resident #016 was standing near and displaying responsive behaviours towards another resident who was displaying a specific behaviour. The CI report identified that PSW #128 witnessed PSW #127 approach resident #016 from behind and physically force the resident back to their seat. During the incident, PSW #128 intervened when they observed resident #016's arms turn red in colour and redirected the resident back to their seat.

The CI occurred in June 2016 but was not reported to the Director until 4 and half hours after the incident had occurred.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02" last revised on April 2016 revealed that any employee or person who becomes 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 or incompetent care or treatment of a resident was required to contact the Ministry of Health and Long Term Care (Director) through the Action Line.

A review of the home's internal investigation revealed that PSW #128 did not immediately report the suspected or witnessed resident abuse incident as per the home's policy.

Inspector #613 interviewed the Administrator, they confirmed that PSW#128 did not immediately report the suspected or witnessed resident incident of abuse as per the home's policy. PSW #128 reported the incident to RN# 130, 3 hours after it had occured. The Administrator stated it was their expectation that all staff comply with the policy for immediate reporting of alleged, suspected or witnessed abuse. [s. 20. (1)]

2. Inspector #617 reviewed a Critical Incident (CI) that was reported to the Director related to resident to resident abuse involving resident #025 who inappropriately touched resident #026.

The CI occurred in June 2016, and the home reported it to the Director one day after the incident had occurred.

A review of resident #025's progress notes identified that in June 2016, RPN #131 had documented a description and their interventions related to the incident involving resident #025 and #026 which was reported to them by a staff member.

A review of the CI indicated that RPN #131 was made aware of the incident and did not notify the manager on call or speak to the RN on duty.

On August 17, 2016, Inspector #617 interviewed the ADOC, who confirmed to the Inspector that RPN #131 was aware that they were responsible to report the CI immediately to the manager on call or the RN on duty and did not report as per the home's policy. The ADOC reported that RPN #131 had recently been trained in mandatory reporting prior to the incident and should have reported the incident immediately but did not. [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 #3: 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 ensure that the results of every investigation undertaken under clause (1) (a) , and every action taken under clause (1) (b) regarding a mandatory report was reported to the Director.

The home submitted a Critical Incident (CI) under the mandatory report category related to staff to resident verbal abuse involving resident #023. A review of the CI indicated that resident #023 had difficulty maneuvering their wheelchair in a congested area where other residents were in their wheelchairs. PSW #120 attempted to assist the resident in their wheelchair away from the congested area. During PSW #120's assistance of resident #023, it was witnessed by other staff that PSW #120 yelled and reprimanded the resident even after the resident was clear of the congested area.

A review of the home's investigation notes concluded that in May 2016, verbal abuse did not occur and that the circumstances of the incident caused PSW #120 to have spoken to resident #023 in an elevated tone of voice which was not intentional but was perceived as "yelling" from witnesses.

On August 16, 2016, the Inspector reviewed the Critical Incident System on the Ministry of Health and Long Term Care Portal and found that the submitted CI was missing an amendment.

A review of the home's policy titled "Zero Tolerance of Abuse Jurisdictional Reporting Requirments-RC-02-01-02 A1" revised on April 2016, indicated that the results of the abuse/neglect investigation and any action(s) taken in response to the incident must be submitted by management within 10 days or earlier using the Critical Incident System (CIS). If the home cannot submit the report within 10 days, it must submit a preliminary report to the MOHLTC Director using the CIS and provide a final report within 21 days.

During an interview with the ADOC, they confirmed that the home's conclusion was that verbal abuse did not occur towards resident #023 and the results of the investigation were not reported to the Director at the time of the inspection. [s. 23. (2)]

2. Inspector #617 reviewed a Critical Incident (CI) that was submitted to the Director under the mandatory report category of staff to resident neglect where resident #004's family member complained regarding concerns about the care provided by PSW #114.

A review of the home's investigation notes concluded that neglect of resident #004 did not occur as it was witnessed by the Activity Aide #132 that in fact resident #004 was properly cared for at the time of the incident.

On August 16, 2016, the Inspector reviewed the Critical Incident System on the Ministry of Health and Long Term Care Portal and found that the submitted CI was missing an amendment.

During an interview with the ADOC, they confirmed that the home's conclusion was that resident #004 was not neglected and the results of the investigation were not reported to the Director at the time of the inspection. [s. 23. (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 the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b) regarding a mandatory report is reported to the Director, to be implemented voluntarily.

Issued on this 7th day of October, 2016

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

Original report signed by the inspector.