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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2017	2016_562620_0031	001072-17, 001822-17	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

ALAIN PLANTE (620), LISA MOORE (613)

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): December 19-23, 2016, and January 18-20, and 23, 2017

This inspection included the following logs related to:

- a critical incident the home submitted regarding an allegation of staff to resident verbal abuse,
- a critical incident the home submitted regarding an allegation of resident neglect and abuse,
- two critical incidents the home submitted regarding two unexpected deaths, and
- a critical incident the home submitted regarding staff to resident abuse.

A Follow-up (report # 2016_562620_0030) and Complaint inspection (report # 2016_562620_0029) were conducted concurrently. As a result, findings from this inspection report are also included in the concurrent Complaint and Follow-up inspection reports.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Support Services Manager (SSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

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

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

4 WN(s)
2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur should have immediately reported the suspicion and the information upon which it was 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.
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.

Inspector #620 reviewed a Critical Incident report (CI) that was submitted to the Director. The report described that on a specified date resident #001 reported to RPN #107 that PSW #105 had yelled at them for having to go to the bathroom too frequently. For further details refer to WN #1, of Follow-up report #2016_562620_0030.

Inspector #620 reviewed the home's investigation records related to the incident. The records indicated that RPN #107 first became aware of the allegation of verbal abuse within hours of it occurring. The On-call Manager then advised RPN #107 to switch PSW #105 to another area of the home on their next scheduled shift and that ADOC #001 would follow up with PSW #105 in two days.

Inspector #620 reviewed submission by the home to the Critical Incident Reporting System and was unable to identify a CI report related to this allegation of abuse.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" with a review date of April 2016. The policy advised that, in cases where the allegation abuse was made against an employee, Management was to ensure they immediately reported the allegation to the MOHLTC.

Inspector #620 interviewed ADOC #001 who confirmed that they became aware of the allegation of verbal abuse within hours of the incident occurrence. They said that they advised the On-call Manager to modify PSW #105's work location to an alternate unit. They confirmed that they had not notified the Director of the allegation of staff to resident abuse until two days after they became aware of the allegation. [s. 24. (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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system, was complied with.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director. The CI report identified that resident #006 had been found partially out of their bed.

A review of the home's policy titled, "Falls Prevention and Management Program," RC-06 -04-01, last revised May 2016, identified that the program would engage resident, family/SDM and the interdisciplinary team to proactively identify and address individual and environmental risk factors and causes of falls. Registered staff were to notify the POA/SDM/family, as required, and communicate with POA/SDM/family per care plan/documented preference.

The Inspector completed a health care record review. It had been documented that resident #006 had been assessed by a registered staff and a small area of altered skin integrity had been noted. A review of resident #006's electronic progress notes on Point Click Care (PCC) identified that their substitute decision- maker (SDM) had not been notified. The SDM had been notified in full of the fall, four shifts after the incident had occurred.

During interviews with several registered staff, RPN #125, RPN #126 and RN #119, they all informed the Inspector that they were expected to notify the SDM as soon as possible after a fall/incident. RN #119, stated they would contact the SDM/family during the night,

if the resident was transferred to the hospital or had sustained a serious injury. RN #119 stated resident #006 had not sustained a serious injury; therefore, they had reported the fall/incident to day staff to notify the SDM/family of the incident.

Inspector #613 interviewed ADOC #104, who stated it was their expectation for registered staff to notify the SDM/family as soon as possible after a fall/incident. ADOC stated the home’s policy had not identified a specific time frame for notification, but they verified that it was the home’s practice to notify the SDM/family right away after a fall/incident. The ADOC verified the home had been late with notifying resident #006’s SDM/family of the incident that had occurred, and they should have been contacted the following day shift. The ADOC stated there had “been a breakdown in communication.”

Inspector #613 interviewed the DOC, who stated it was their expectation that staff notify the SDM/family right away after a fall/incident, unless it occurred during the night shift and the resident had no injury. They indicated that if a fall/incident occurred during the night shift, the following day shift was expected to contact the SDM/family. The DOC confirmed that staff were late with notifying resident #006’s SDM/family of the fall/incident. [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 ensuring that the licensee's falls prevention program/policy 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee, was immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff.

Inspector #620 reviewed a CI report that was submitted to the Director. For further details refer to WN #1, of follow-up report #2016_562620_0030.

Inspector #620 reviewed the home's investigation records related to the incident. The records indicated that RPN #107 first became aware of the allegation of verbal abuse on a specified date. RPN #107 described that they notified the On-call Manager within hours of the occurrence, who in turn consulted with ADOC #001 immediately after receiving the allegation. The On-call Manager then advised RPN #107 that ADOC #001 would follow up with PSW #105 in two days.

Inspector #620 reviewed the home's investigation records. There was no evidence in the investigation notes that indicated that an investigation was immediately started; rather, the investigation began two days after they were made aware of the allegation.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" with a review date of April 2016. The policy advised that, in cases where the allegation abuse was made against an employee, Management was to promptly initiate an investigation.

Inspector #620 interviewed ADOC #001 who confirmed that they became aware of the allegation of verbal abuse on the night it occurred. They confirmed that they had not immediately started an investigation. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated; specifically, abuse of a resident by anyone, and neglect of a resident by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Inspector #620 reviewed a CI report that was submitted by the home, to the Director. The report was initiated as a result of an unexpected death. According to the CI report the resident had a fall prevention device in place; however, the device had not been activated during a fall incident. The resident passed away in hospital. For further detail refer to WN #2 of Follow-up report #2016_562620_0030.

A review of resident #004's clinical record revealed all shifts were to monitor the resident's fall prevention device to ensure that it was in place, and working properly.

A review of the manufacturer's instructions for the fall prevention device indicated that when the device was being used in a bed, the user was to make adjustments to the device to ensure that it would operate as required.

Inspector #620 interviewed PSW #106 who stated that they were the first person to find resident #004 post fall. They stated that the resident had the fall prevention device but because the device was not adjusted, it had not been activated. PSW #106 denied adjusting the fall prevention device.

Inspector #620 interviewed ADOC #001 who stated the fall prevention device was determined to be functional and that they were unaware if the staff had checked the device's functionality. [s. 23.]

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.

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 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) :	ALAIN PLANTE (620), LISA MOORE (613)
Inspection No. / No de l'inspection :	2016_562620_0031
Log No. / Registre no:	001072-17, 001822-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 24, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, 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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that:

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

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.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur should have immediately reported the suspicion and the information upon which it was 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.
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.

Inspector #620 reviewed a Critical Incident report (CI) that was submitted to the Director. The report described that on a specified date resident #001 reported to RPN #107 that PSW #105 had yelled at them for having to go to the bathroom too frequently. For further details refer to WN #1, of Follow-up report #2016_562620_0030.

Inspector #620 reviewed the home's investigation records related to the incident. The records indicated that RPN #107 first became aware of the allegation of verbal abuse within hours of it occurring. The On-call Manager then advised RPN #107 to switch PSW #105 to another area of the home on their next scheduled shift and that ADOC #001 would follow up with PSW #105 in two days.

Inspector #620 reviewed submission by the home to the Critical Incident Reporting System and was unable to identify a CI report related to this allegation of abuse.

Inspector #620 reviewed the home's policy titled, “Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences” with a review date of April 2016. The policy advised that, in cases where the allegation abuse was made against an employee, Management was to ensure they immediately reported the allegation to the MOHLTC.

Inspector #620 interviewed ADOC #001 who confirmed that they became aware of the allegation of verbal abuse within hours of the incident occurrence. They said that they advised the On-call Manager to modify PSW #105's work location to an alternate unit. They confirmed that they had not notified the Director of the allegation of staff to resident abuse until two days after they became aware of the allegation.

The decision to issue this compliance order was based on the scope which had been identified as isolated, the severity which indicated actual harm, and the compliance history which despite previous non-compliance having been issued with two voluntary plans of correction under report #2016_395613_0007 and #2015_281542_0005, and a written notice under report #2014_281542_0007;

non-compliance continued with this section of the legislation. (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2017

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 24th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alain Plante

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