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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2017	2017_616542_0019	005830-17, 009346-17, 011491-17, 011563-17, 012978-17, 014388-17, 021804-17, 021969-17, 022950-17, 023255-17, 023648-17, 023684-17, 023764-17, 024248-17, 024332-17, 024839-17	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

JENNIFER LAURICELLA (542), AMY GEAUVREAU (642), LISA MOORE (613), RYAN GOODMURPHY (638), STEPHANIE DONI (681)

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): October 30 - November 9, 2017.

The following intakes were completed during this inspection:

Five intakes related to staff to resident abuse/neglect.

Six intakes related to falls and improper transferring.

Three intakes related to resident to resident abuse.

Two intakes related to an unexpected death of a resident.

A Follow Up Inspection #2017_616542_0020 and a Complaint Inspection #2017_616542_0018 were completed concurrently with this inspection. All non compliances under section s. 6 (7) and s. 20 were issued within the Follow Up Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Acting Assistant Director of Care, Assistant Director of Care, Dietary Manager, Registered Dietitian (RD), scheduling staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

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, employee files, staffing assignments and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 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 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director. The CI report indicated, that PSW #118 provided an improper transfer to resident #010, which resulted in the resident sustaining an injury. The CI report stated that PSW #118 left resident #010 sitting on the side of the bed unattended while they went to the door to find another staff to assist them. As a result, resident #010 fell off of their bed and onto the floor.

A review of the care plan identified different interventions under two areas of the foci with regards to resident #010's transferring status. One intervention indicated that resident #010 was to be transferred with a specific type of lift and another intervention that indicated that they could not longer safely use that lift.

A review of the home's policy titled, "Care Planning and Assessments" last revised April

2017, identified that the nurse would ensure that the care plan was current. As the resident's status changed, members of the interdisciplinary team were to update the plan of care so that at any point in time, the care plan continued to be reflective of the current needs of the resident.

During interviews with PSW #118, PSW #117 and RPN #116, they all verified that resident #010 required a specific lift for all transfers and that all staff were aware. PSW#112 indicated that the care plan should have provided clear directions for all staff and corrected the paper care plan. RPN #116 updated the care plan on PointClickCare (PCC) and printed a revised copy. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Two Critical Incident (CI) reports were submitted to the Director, regarding potential sexual abuse involving resident #011 and resident #012.

Inspector #681 reviewed resident #012's electronic care plan. Resident #012's current plan of care, instructed staff to ensure that a specific intervention was applied to their door. Resident #012's door was to be closed at all times to direct co-resident from entering their room. Staff were also directed to monitor resident #012 while, the specific intervention was in front of their door to ensure that it did not deter them from leaving their room.

Inspector #681 made the following observations of resident #012's room; on five separate occasions the required specific intervention was not in place.

During an interview with Inspector #681 on November 2, 2017, RN #120 verified that a stop sign applied to the door of resident #012's room was a current intervention in resident #012's care plan. RN #120 indicated that the specific intervention was no longer required because resident #012 had been transferred to a different unit. RN #120 verified that the care plan was not updated to reflect resident #012's current needs.

In an interview with Inspector #681 on November 2, 2017, Acting DOC #103 verified that the specific intervention was no longer required because resident #012 was relocated on a different unit. Acting DOC #103 indicated that this intervention should have been removed from the resident's care plan. [s. 6. (10) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident and that the plan of care is reassessed, reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan was no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Ontario Regulation 79/10 (O. Reg. 79/10) defines sexual abuse as any non-

consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Two Critical Incident (CI) Reports were submitted to the Director, regarding potential sexual abuse involving resident #011 and resident #012.

Inspector #681 reviewed the electronic health care record for resident #012. Included in resident #012's electronic health care record was a progress note written by RPN #119. The progress note indicated that resident #011 was observed walking in the hall, to be in a state of undress. Resident #012 was subsequently observed to be sitting in their room also in a state of undress. The progress note also indicated that RPN #119 had made the RN, ADOC, physician, and Administrator aware of the situation.

In an interview with Inspector #681 on November 1, 2017, RPN #119 verified that they had advised both the ADOC and the Administrator about the incident that had occurred involving resident #011 and resident #012 on the day that the incident occurred.

Inspector #681 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last updated April 2017, which indicated that suspected or witnessed abuse of a resident must be reported to the Ministry of Health and Long Term Care.

Inspector #681 reviewed all of the CI reports submitted to the Director by Extendicare Maple View during the time of the incident. No CI report was submitted by the home about a potential sexual abuse that occurred on that specific day, involving resident #011 and resident #012.

In an interview with Inspector #681 on November 2, 2017, the Acting DOC #103 stated that a CI report had not been submitted to the Director related to the incident involving resident #011 and resident #012. Acting DOC #103 stated that the CI reports were submitted about two other previous incidents by a former DOC who was no longer employed at the home. Acting DOC #103 indicated that a CI report was not submitted to the Director regarding the current incident because the home did not believe that the interaction between residents #011 and #012 was considered to be potential sexual abuse.

In an interview with Inspector #681 on November 3, 2017, the Administrator verified that the home did not believe that the incident was considered sexual abuse and that it

needed to be reported because there were no signs that intercourse. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director. The CI report identified that resident #015 had a fall and sustained an injury. The CI report revealed that after providing care to the resident, PSW #134 attempted to remove a transfer sling from under the resident after transferring them into bed. Resident #015 slipped on the transferring sling and fell from the bed to the floor. PSW #134 and PSW #145 were involved in the transfer of resident #015 from the chair to their bed; however, only PSW #134 was involved in the removal of the transfer sling.

A review of the home's policy titled, "Safe Lifting with Care Program – Mechanical Lift Procedures" last revised August 2017, identified that two trained staff were required at all times when performing a mechanical lift, two staff members to position the sling and two staff members to remove the sling from underneath the resident.

A review of resident #015's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) at time of the fall, identified that resident #015 required total assistance of two staff members for bed mobility and transfers.

The Inspector reviewed the home's internal investigation file that revealed that both PSW #134 and PSW #145 received discipline for their failure to follow the Safe Lifting with Care policy.

During an interview with the Acting Director of Care, they verified that both PSW #134 and PSW #145 did not use safe transferring techniques when assisting resident #015 out of the transfer sling and did not follow the home's policy for the sling use and transferring [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure they informed the Director of an incident under subsection (1), (2) or (3.1) with in 10 days of becoming aware of the incident, or sooner if required by the director to make a report in writing to the Director setting out the immediate actions that had been taken to prevent recurrence.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director on June 23, 2017. The CI report identified that resident #017 had a fall and sustained an injury. As a result of the fall, the resident was transferred to the hospital on the same date.

Three days after the submission of the CI report, the Director had requested the licensee to amend the CI report with specific details of resident #017's health status, care needs prior and post fall and the actions taken to prevent recurrence. An amendment from the licensee was not provided to the Director as of November 6, 2017.

During an interview on November 6, 2017, with the Administrator, they verified that the CI report had not been amended as requested by the Director. [s. 107. (4) 4. i.]

Issued on this 17th day of January, 2018

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

Original report signed by the inspector.