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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 7, 2018	2018_616542_0011	025551-17, 028515-17, 000095-18, 000585-18, 001493-18, 001633-18, 004108-18, 006035-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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), LISA MOORE (613), LOVIRIZA CALUZA (687)

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): April 30, 2018 - May 11, 2018.

A Follow Up Inspection # 2018_616542_0009 and a Complaint Inspection # 2018_616542_0010 were completed concurrently with this Critical Incident Inspection. PLEASE NOTE: A written notification and Compliance Order (CO)

related to LTCHA, 2007, c.8, s. 20 (1) and s. 6 (7) were identified in this Inspection and have been issued in Inspection Report #2018_616542_0009 dated, June 7, 2018, which was conducted concurrently with this inspection.

The following intakes were completed in this Critical Incident Inspection:

Two intakes, related to plan of care;

One intake, related to plan of care and safe and secure home;

One intake, related to plan of care, responsive behaviours, maintenance and falls prevention;

Two intakes, related to prevention of abuse and responsive behaviours and

Two intakes, related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPNs), the Dietary Manager, the Office Manager, Physicians, the Personal Support Services Manager, the Director of First Impressions, Physiotherapists, maintenance staff, Personal Support Workers (PSWs), Scheduling staff, the Social Service Worker, Family members and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
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)**
- **0 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. (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 the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director which, identified that resident #020 had a fall resulting in an injury for which the resident was taken to the hospital and resulted in a significant change in resident #020's health status.

A review of resident #020's current care plan revealed an intervention under the Fall foci that the resident was to have a specific intervention in place.

During an observation on May 7, 2018, Inspector #613 noted that resident #020 did not have the specific intervention in place, but rather they had a different intervention being used.

A review of the progress notes on Point Click Care (PCC) revealed that Physiotherapist #149 had removed the specific intervention and applied a different intervention, and that they had informed Assistant Director of Care #145.

A review of the home's policy titled, "Care Planning" last revised April 2017, identified that the nurse would ensure that the care plan was current. As the resident's status changed, nurse/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 and

preferences of the resident.

During an interview with PSW #127, they stated that physiotherapist had removed the specific intervention and applied a different intervention. PSW #127 reviewed the care plan with the Inspector and confirmed that the care plan did not identify the use of the current intervention; but rather, the care plan directed staff to use the previous intervention.

During an interview with RPN #122, they reviewed the resident's plan of care and verified that resident #020's care plan was not updated and that registered staff were expected to update the care plan as required for resident changes and the care plan should have been updated when informed that the new intervention was being used.

During an interview with the Acting DOC #110, they confirmed that it was the expectation of registered staff to update the care plans when the residents' care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
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. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff led to the report of the actions taken in response to the incident including the outcome or current status of the individual or individuals who were involved in the incident. r. 104 (1) 3. v.

A Critical Incident (CI) Report was submitted to the Director in relation to alleged neglect of resident #016 by PSW #100.

On May 10, 2018, Inspector #687 conducted a document review in an attempt to locate pertinent documents related to the alleged neglect of resident #016 by PSW #100. No

documents related to the outcome or current status of the individual or individuals who were involved in the incident were found.

In an interview with the Acting DOC on May 10, 2018 at 1300 hours, Inspector #687 requested investigation notes regarding the alleged neglect of resident #016 by PSW #100. The Acting DOC responded that they would search for the investigation notes immediately.

In a subsequent interview by Inspector #687 with the Acting DOC on May 10, 2018 at 1513 hours, the Acting DOC stated that they could not locate investigation notes for the alleged care neglect of resident #016 by PSW #100.

Inspector #687 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", last updated on April 2017, which indicated that Extendicare had implemented a zero-tolerance policy that took all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents which included but was not limited to:

- promptly and thoroughly investigate all alleged or reported incidents in a fair and transparent manner,
- identify and address root causes using quality improvement methods and tools and interdisciplinary care planning strategies.

In an interview of the Acting DOC, they stated that to their recollection, the alleged incident of resident #016 care neglect by PSW #100 was unfounded but acknowledged that they had no investigation notes to support this, as the previous DOC who completed the investigation was no longer employed by the home. [s. 104. (1) 4. ii.]

WN #3: 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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
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).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 action that had been taken to prevent recurrence.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director which, identified that resident # 002 had a fall resulting in an injury for which the resident was taken to the hospital and which resulted in a significant change in resident #002's health status.

On November 10, 2017, the Director had requested the licensee to amend the CI report with specific details of resident #002 status and specific actions and/or strategies implemented to prevent recurrence. An amendment from the licensee was not provided to the Director as of May 3, 2018.

During an interview with the Assistant Director of Care (ADOC) #153 who was identified as the person initiating the CI report. The ADOC #153 indicated they did not amend the CI report, rather that the former Director of Care would have been responsible for amending the CI report.

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

Issued on this 8th day of June, 2018

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

Original report signed by the inspector.