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 prévue 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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2019	2019_633577_0005	030991-18, 031236-18, 001690-19, 002344-19	Complaint

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

DEBBIE WARPULA (577), AMY GEAUVREAU (642), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 4-8, 2019.

The following intakes were inspected upon during this Complaint inspection: two logs related to falls and resident care concerns; two logs related to staffing and resident care concerns.

A Critical Incident System (CIS) inspection #2019_633577_0006 and a Follow Up inspection #2019_633577_0007 were conducted concurrently with this follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Regional Director for Extendicare, Administrator, Senior Director of Care (DOC), Director of Care (DOC), Assistant Director of Care (ADOC #1), Dietary Manager, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Physiotherapist Assistant (PTA), Programs Manager, Activity Aide, staffing scheduler, Resident Assessment Instrument (RAI) coder, a family member 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, reviewed numerous audits, and staffing schedules and staffing patterns.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint had been received by the Director concerning the care of resident #002. The complaint indicated that the resident's substitute decision-maker (SDM) had requested that staff conduct specific health surveillance for resident #002 to determine the potential for illness. The surveillance had not been completed as requested and resident #002 was hospitalized with illness.

Inspector #642 reviewed a document for resident #002 which had identified resident #002 as having a specific ailment and the physician had ordered medication.

Inspector #642 interviewed the SDM who reported that resident #002 had completed their medication and five days after the completion of the medication, they had requested that staff conduct surveillance as they felt resident #002 was still unwell. The SDM further reported that a week later, they asked staff for the test results and was told by RPN #116 that the surveillance had not occurred or been ordered.

Inspector #642 reviewed resident #002's progress notes which indicated that the resident was transferred to an acute care hospital a short time after the completion of the medication, and had been diagnosed with a specific illness.

Inspector #642 interviewed RPN #116, who stated that if resident #002's SDM had requested the health surveillance, there should have been a doctor's order, and they confirmed that it had not been completed; therefore the substitute decision-maker was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Inspector #642 reviewed the home's policy, "Care Planning and Assessments," revised April 2017, which indicated under the procedures by nurse: Provide an opportunity for the resident and/or Substitute Decision-Maker (SDM) to participate in developing individual care and treatment goals.

Inspector #642 interviewed ADOC #1, who had investigated the SDM's complaint for resident #002. They reported that there wasn't a physican's order, or communication to the physician, for the specific health surveillance and they stated the SDM had not been given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

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 resident's substitute decision-maker, if any, and any other person designated by the resident or substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 15th day of February, 2019

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

Original report signed by the inspector.