Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
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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
Jul 4, 2019	2019_776613_0018	010159-19, 010801-19, 011191-19	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

LISA MOORE (613), JENNIFER LAURICELLA (542)

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): June 17 - 21, 2019.

The following complaints were inspected during this inspection:

Two Complaints that were submitted to the Director regarding the provisions of care; and,

One Complaint that was submitted to the Director regarding staff to resident neglect.

A concurrent Critical Incident Inspection #2019_776613_0019 was also conducted with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Senior Director of Care (Senior DOC), Director of Care (DOC), Assistant Directors of Care (ADOCs), Medical Director (MD), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation files, human resource files, and licensee policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #613 reviewed a Complaint that was reported to the Director, related to an allegation of neglect involving resident #001. A Critical Incident (CI) report was also submitted by the home, related to this incident.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

During an interview with the complainant, they stated that they had visited resident #001, and on their arrival, PSW #105 informed the complainant that they had just put resident #001 to bed and had changed their continent product. The complainant stated that when they arrived to resident #001's room, they observed resident #001 lying in bed in a specific position, which the resident should not have been positioned. The complainant stated that there was a sign above the resident's bed that stated how to position them. As well, resident #001 did not have a device applied that was supposed to be applied daily and there was a full glass of water on resident #001's bedside table. The complainant offered resident #001 two glasses of water and they drank both glasses quickly. The complainant then went to reposition resident #001 and noted an odour, they then got PSW #105 to assist with changing resident #001's continent product. The complainant and PSW #105 removed the continent product and the complainant observed that resident #001 was wearing a specific type of continent product and the continent product was saturated, the gel in the continent product had broken and the gel had come out and was on resident #001's skin, as well, there was stool on resident #001's skin. The complainant stated resident #001's "bottom" was red as a result and that PSW #105 did not know if there was cream to apply to their skin. The complainant voiced they were concerned as resident #001's care plan was not being followed and that PSW #105 had neglected to provide them with the appropriate care.

A review of resident #001's care plan at time of the incident, identified the following interventions;

-specific body part would be washed and dried thoroughly and a roll would be placed at all times
-staff to check and change product as needed in the morning, and after lunch, at 1600

hour rounds, bedtime and at last rounds.
-wears continent products daily (Specific type on days, evenings and nights)
-drinks well with a straw; preferences identified over water. But they would drink water on occasion. Staff to offer a variety of fluids.
-resident must be positioned in a specific manner, as they would develop areas of altered skin integrity quickly. Instructions were posted to ensure positioning and turning at specific times.

A review of the home's internal investigation file identified that the home had completed their investigation and determined that the allegations of neglect were founded and that PSW #105 had not provided care to resident #001, as per their care plan. The investigation notes indicated that PSW#105 did not know what resident #001's care plan stated and described that they had not checked the resident for approximately five hours on a specific shift, and that they should have changed the resident's continent product. The investigation notes also indicated that PSW #105 did not offer resident #001 fluids during their shift and confirmed there was a sign above resident's bed that stated how resident #001 was to be positioned. The investigation notes indicated that PSW #105 had stated they "did not" read the care plans, because they know what care to provide to the residents.

A review of PSW #105's employment records revealed six instances (between 2017 and 2019) where the licensee had taken disciplinary action as a result of performance issues related to neglect.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program last updated June 2019, identified that Extendicare was committed to providing a safe and secure environment in which all resident's were treated with dignity and respect and protected form all forms of abuse or neglect at all times.

During an interview with the Senior Director of Care (Senior DOC), they confirmed that PSW #105 had not complied with the licensee's Zero Tolerance of Resident Abuse and Neglect Policy. The Senior DOC stated that PSW #105 did not ensure that resident #001 had their device applied, had not ensured their continent product was checked or changed, and had not ensured the resident was wearing the appropriate continent product, had not repositioned the resident as per the instructions or provided a variety of fluids. The Senior DOC stated that resident #001 had been in a specific type of continent brief for approximately 10 hours on a specific date.

During an interview with the Administrator (ADM), they stated that based on PSW #105's comments during the home's investigation and their past work performance history, they had determined neglect occurred. PSW #105 had stated during the home's investigation that they had checked resident #001 at the start of their shift and resident had a specific type of continent product on that was allegedly dry and stated they did not attend to the resident until approximately five hours, when they had transferred them into their bed with the assistance of another PSW, stating they would go back later and change their continent product; however, PSW #105 never went back to provide care to resident #001. The ADM stated that PSW #105 had documented in Point of Care (POC) that they had changed resident #001's continent product at a specific time; however, it was evident that they did not, the continent product was saturated, the gel in the continent product had broken and the gel had come out onto their skin. The ADM stated PSW #105 had neglected resident #001 since after a specific meal and never went back to change resident #001 or provide them with care on a specific date. [s. 19. (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 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 the 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 had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed a CI report that was submitted to the Director, identifying neglect of resident #001 by PSW #105. A Complaint was also reported to the Director related to this incident.

The CI report identified that the Senior DOC had received a voice message from resident #001's substitute decision-maker (SDM) and returned the telephone call later on the same date. As per the CI report, resident #001's SDM voiced concerns regarding the lack of care resident #001 had received on a specific date. See WN #1 for specific details.

The CI report was submitted to the Director, two days after the allegations of neglect had been reported to the Senior DOC.

A review of the licensee's policy titled, "Zero Tolerance of Resident and Abuse and Neglect: Response and Reporting" last revised June 2019, identified that any employee or person who became aware of 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 suspected or witnessed abuse or neglect that causes or may cause harm to a resident are required to contact the Ministry of Health and Long Term Care (Director) through the Action Line.

During an interview with the Senior DOC, they indicated that any alleged abuse or neglect was to be reported to the Director immediately. The Senior DOC verified that this incident was not reported immediately, as required. [s. 24. (1)]

Issued on this 5th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou 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) :	LISA MOORE (613), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2019_776613_0018
Log No. / No de registre :	010159-19, 010801-19, 011191-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 4, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
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 :	Marva Griffiths

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:

A) Ensure that all resident are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #613 reviewed a Complaint that was reported to the Director, related to an allegation of neglect involving resident #001. A Critical Incident (CI) report was also submitted by the home, related to this incident.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

During an interview with the complainant, they stated that they had visited resident #001, and on their arrival, PSW #105 informed the complainant that they had just put resident #001 to bed and had changed their continent product. The complainant stated that when they arrived to resident #001's room, they observed resident #001 lying in bed in a specific position, which the resident should not have been positioned. The complainant stated that there was a sign above the resident's bed that stated how to position them. As well, resident

#001 did not have a device applied that was supposed to be applied daily and there was a full glass of water on resident #001's bedside table. The complainant offered resident #001 two glasses of water and they drank both glasses quickly. The complainant then went to reposition resident #001 and noted an odour, they then got PSW #105 to assist with changing resident #001's continent product. The complainant and PSW #105 removed the continent product and the complainant observed that resident #001 was wearing a specific type of continent product and the continent product was saturated, the gel in the continent product had broken and the gel had come out and was on resident #001's skin, as well, there was stool on resident #001's skin. The complainant stated resident #001's "bottom" was red as a result and that PSW #105 did not know if there was cream to apply to their skin. The complainant voiced they were concerned as resident #001's care plan was not being followed and that PSW #105 had neglected to provide them with the appropriate care.

A review of resident #001's care plan at time of the incident, identified the following interventions;

-specific body part would be washed and dried thoroughly and a roll would be placed at all times
-staff to check and change product as needed in the morning, and after lunch, at 1600 hour rounds, bedtime and at last rounds.
-wears continent products daily (Specific type on days, evenings and nights)
-drinks well with a straw; preferences identified over water. But they would drink water on occasion. Staff to offer a variety of fluids.
-resident must be positioned in a specific manner, as they would develop areas of altered skin integrity quickly. Instructions were posted to ensure positioning and turning at specific times.

A review of the home's internal investigation file identified that the home had completed their investigation and determined that the allegations of neglect were founded and that PSW #105 had not provided care to resident #001, as per their care plan. The investigation notes indicated that PSW#105 did not know what resident #001's care plan stated and described that they had not checked the resident for approximately five hours on a specific shift, and that they should have changed the resident's continent product. The investigation notes also indicated that PSW #105 did not offer resident #001 fluids during their shift and

confirmed there was a sign above resident's bed that stated how resident #001 was to be positioned. The investigation notes indicated that PSW #105 had stated they "did not" read the care plans, because they know what care to provide to the residents.

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A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program last updated June 2019, identified that Extendicare was committed to providing a safe and secure environment in which all resident's were treated with dignity and respect and protected form all forms of abuse or neglect at all times.

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was saturated, the gel in the continent product had broken and the gel had come out onto their skin. The ADM stated PSW #105 had neglected resident #001 since after a specific meal and never went back to change resident #001 or provide them with care on a specific date.

The severity of this issue was determined to be a level 3, as there was actual harm and risk to the residents. The scope of the issue was a level 1, as it related to one of the residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

-Director's Referral (DR) issued October 23, 2018 (2018_668543_0020);
-Compliance Order (CO) issued June 7, 2018 (2018_616542_0010);
-CO issued February 24, 2017 (2016_562620_0030). (613)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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