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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 15, 2019	2019_509613_0023	014139-19, 015060-19	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)

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): August 6 - 9, 2019.

The following complaints were inspected during this inspection:

Two Complaints that were submitted to the Director regarding the provisions of care.

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

The Inspector 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 file, and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #613 reviewed a complaint that was submitted to the Director, related to provision of care concerns of resident #001 by staff regarding an incident that occurred.

During an interview with the complainants, they stated that on a specific date, resident #001 rang their call bell for assistance to the bathroom. They alleged that PSW #105 entered the resident's room, turned off the call bell and then moved the resident away from their bed and call bell and left the resident unassisted for 40 minutes, prior to assisting them to the bathroom.

During an observation, the Inspector viewed a a document which directed staff to ensure the call bell was placed within the resident's reach.

A review of the video surveillance showed that resident #001 was sitting in their mobility aid at the side of their bed, with the call bell placed on their bed, when they had rang the call bell to receive assistance with toileting. PSW #105 was seen entering the room and

turning off the call bell and moving the resident to the end of their bed, facing the doorway. Resident #001's call bell was observed on their bed and out of their reach. The video surveillance showed that resident #001 had been without access to their call bell for 40 minutes.

A review of the licensee's policy titled, "Nurse Call System" (RC-08-01-01) last revised June 2019, identified that care staff were to ensure that the call bell was easily accessible to the resident at all times while the resident was in their room.

A review of resident #001's care plan identified as an intervention that staff were to ensure the resident's safety and that their call bell was to be placed within their reach as they would ring for assistance as required.

During interviews with Personal Support Worker (PSW) #105, PSW #108 and PSW #109, they stated that a resident's call bell was to always be within their reach, at all times, when a resident was in their room.

During interviews with the Director of Care (DOC) and Assistant Director of Care (ADOC) #103, they confirmed that resident #001's call bell was not within their reach on a specific date. The DOC stated that a call bell should have been within a resident's reach while they were in their room. [s. 17. (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 to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who was incontinent and had been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

Inspector #613 reviewed a complaint that was submitted to the Director, related to provision of care concerns of resident #001 by staff regarding an incident that occurred on a specific date.

During an interview with the complainants, they stated that on a specific date, resident #001 rang their call bell for assistance to the bathroom. They alleged that PSW # 105 entered the resident's room, turned off the call bell and then moved the resident away from their bed and call bell and left the resident unassisted for 40 minutes, prior to assisting them to the bathroom. The family member stated that they arrived to the home, when the resident was in the bathroom. They further alleged that there was a "puddle of urine" on the floor, as resident #001 had to wait 40 minutes to get taken to the bathroom and that the resident was on a routine to be toileted at a specific times.

A review of the video surveillance showed that resident #001 was sitting in their mobility aid at the side of their bed, with the call bell placed on their bed. PSW #105 was seen entering the room at a specific time and turning off the call bell and moving resident #001, while in their mobility aid to the end of the bed, facing the doorway. Resident #001 informed PSW #105 that they had to go to the bathroom and PSW #105 informed the resident that they had to get a mechanical lift. Another PSW, (PSW #112) entered the resident's room, at a later time, and resident #001 informed the PSW that they had to go to the bathroom. PSW #112 informed the resident that there was only one mechanical lift on the unit and that they were waiting for the lift to be available. The video surveillance showed that resident #001 had not received assistance to the bathroom as requested for 40 minutes, when PSW #105 and PSW #112 returned to assist the resident to the bathroom.

A review of the licensee's policy titled, "Continence Management Program" (RC-14-01-01) last revised February 2017, indicated that the home would implement a continence management program that included the promotion of continence and appropriate toileting routine to ensure the continence program was being managed effectively and that care staff would follow a resident's plan of care. The registered staff/care staff would provide residents with the support and/or assistance they required to improve, maintain or prevent deterioration of current functioning, maximize independence, promote comfort and privacy, and maintain dignity.

A review of resident #001's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and Resident Assessment Protocols (RAPS) indicted that resident #001 had a specific level of continence and required a specific level of assistance. The goal was to ensure resident #001 was clean and dry and to ensure that they received the necessary assistance from the staff with their toilet use.

A review of resident #001's care plan identified that the resident was on a toileting program, as per the resident's request and that resident #001 would ring their call bell to be toileted at specific times. The care plan also indicated that resident #001 required required a specific level of assistance.

During an interview with PSW #105 they confirmed that they did not toilet resident #001 when the resident had requested, as they could not find a mechanical lift and that they were expected to follow the resident's plan of care for continence.

During an interview with the DOC and ADOC #103, they confirmed that resident #001 should not have waited 40 minutes to be toileted. The DOC stated that PSW #105 had not met the needs of resident #001. [s. 51. (2) (c)]

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 each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

WN #3: 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).

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 direction to staff and others who provided direct care to resident #002.

Inspector #613 reviewed a complaint that was submitted to the Director, related to provision of care concerns of resident #002 by staff regarding an alleged incident that occurred on a specific date.

A review of resident #002's care plan indicated that they were to be toileted regularly throughout shifts to maintain their continence.

A review of the licensee's policy titled, "Continence Management Program" (RC-14-01-01) last revised February 2017, defined scheduled toileting as an activity preformed according to specific routine times communicated clearly to resident and caregivers. Toileting routines was described as a routine put in place by staff, based on specific times and utilized when the resident was unable to sense or control the urge.

During an interview with PSW #110 and PSW #112 stated that the care plan was not specific for toileting times and should identify times to toilet the resident. Both PSW's indicated the care plan was not clear for the toileting times for resident #002.

During an interview with the DOC, they stated that resident #002's care plan was not clear and that is should identify specific times for toileting based on resident #002's individualized needs. [s. 6. (1) (c)]

Issued on this 15th day of August, 2019

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

Original report signed by the inspector.