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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2014	2014_281542_0007	S-000068-14	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)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 3, 4, 5, 2014.

Please Note;
Admission and Discharge, Hospitalization and Change of Condition Inspection Protocols were opened in error during this inspection and were not utilized.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Registered staff, Personal Support Worker(s), Residents and Family Members.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. On March 3, 4, 5, 2014 Inspector reviewed resident's progress notes in relation to the behaviours that the resident had exhibited towards a female co-resident. Inspector noted numerous entries where the male resident either attempted to lure a female resident into his room, touch or kiss her and where the male resident was found to be physically touching the female resident. These behaviours were documented in the progress notes over a couple of months. Inspector reviewed resident's current care plan which indicated under the Behavioural Symptoms section the following; that resident is to be kept away from female residents by involving resident in activities, distraction, redirection and pro attention plan, such as half hour checks while up; ensure that resident is the last one to dining room and last one out; spend 1:1 time with resident for 2-3 min before any behaviour occurs to prevent escalation. Current care plan also states that resident will seek out female residents with intent and will make sexual advances towards them, as evidenced by touching them without consent when staff not in vicinity and attempts to push them to quiet areas such as dining room or own room. If found touching another female resident intervene immediately, orientate, distract and redirect resident.
Inspector reviewed the resident's, Daily Care Flow sheets, completed by the Personal Support Workers (PSWs). Over 8 days, PSWs documented that resident exhibited the behaviour of "physical touching" 7/8 days.
On March 4, 2014 during the evening shift, Inspector observed male resident in the dining room with female residents and no staff present. Resident proceeded towards a female resident when the female resident yelled "Nurse" and a staff member came around the corner and removed resident from this female resident.
On March 5, 2014 Inspector interviewed Assistant Director of Care (ADOC) and made her aware of the Inspector's observation, ADOC informed Inspector that the resident is not to be left alone with female residents, someone should be watching resident and staff are aware of this.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident, as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident, as specified in the plan, 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 :

A Critical Incident was reported to the Director, outlining a resident's sexual abuse towards a co-resident. Inspector reviewed the report on March 5, 2014 and noted that the resident was sexually abusive to this co-resident on two separate occasions as documented by the registered staff and as indicated in the critical incident report. Inspector interviewed the Assistant Director of Care on March 5, 2014 who confirmed that the Director was not notified immediately when the incident took place.

The licensee failed to ensure that when 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. [s. 24. (1)]

Issued on this 21st day of March, 2014

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

Jennifer Lauricella