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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 12, 2016	2016_270531_0028	001879-16, 035846-15, 003157-16,	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 COBOURG
130 NEW DENSMORE ROAD COBOURG ON K9A 5W2

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

SUSAN DONNAN (531)

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): August 2, 3, 4, 5 and 8, 2016

The following logs were completed as part of this inspection:
Log #035846-15 resident to resident alleged abuse
Log #001879-16 staff to resident alleged abuse
Log #003157-16 resident to resident alleged abuse

During the course of the inspection, the inspector(s) spoke with residents, residents substitute decision makers, personal support workers, registered practical nurses, registered nurses and the director of care.
During the course of the inspection the inspector toured the home, reviewed resident health care records, observed resident care and services and appropriate policies and procedures.

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

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	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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force were immediately notified of the alleged abuse of resident #003.

In reference to log # 003157-16

Under O. Reg. 79/10 79/10 s. 2 (1)c, physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.
Review of the health care record and critical incident #2851-000006-16 for resident #005 indicated that the resident has multiple comorbidities including dementia with responsive behaviours. On specified date PSW #109 found resident #005 in resident #003's room striking resident #003 with a walker and accusing resident #003 of being in the wrong bed. Resident #003 sustained injuries.

August 8, 2016 during an interview with RPN #100 she indicated that both she and the Director of Care assessed resident #003 and resident #005. RPN #100 confirmed that she contacted both residents substitute decision makers, the physician and the Ministry but did not contact the police force.

Subsequently during an interview with the Director of Care and review of the internal documentation she confirmed that the appropriate police force were not immediately notified of the incident. [s. 98.]

2. In reference to log # 035846-15

Review of the health care record and critical incident #2851-000042-15 for resident #004 indicated that the resident has multiple comorbidities which included dementia with responsive behaviours. On a specified date PSW #107 found resident #004 and resident #003 on the floor in the hallway. Resident #003 alleged that resident #004 walked up to him/her and slapped and pushed him/her to the ground. RPN #110 assessed resident #003 and noted specific injuries requiring a transfer to the hospital for further examination. Resident #004 did not sustain any injuries.

During an interview with PSW #107 he indicated that he found resident #003 and #004 on the floor in the hallway. PSW #107 indicated that resident #003 alleged that resident #004 slapped and pushed him/her to the ground. PSW #107 indicated that resident #003 was complaining of pain when being assessed by RPN #110.
RPN #110 is currently on leave and not available for an interview.

Subsequently during an interview with the Director of Care and review of the internal documentation she confirmed that the police were not notified of the incident.
The Director of Care indicated that it has been identified that the police were not notified

and that the process will be reviewed and reinforced with all registered staff. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 12th day of August, 2016

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

Original report signed by the inspector.