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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_657681_0008	021694-17, 023469-17	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 FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

STEPHANIE DONI (681)

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): October 10-13, 2017.

This Critical Incident System (CIS) inspection is related to three critical incidents the home submitted regarding:
- One intake related to resident to resident abuse.
- One intake related to staff to resident abuse.
- One intake related to an unexpected death.

A Follow-up inspection #2017_657681_0009 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Dietitian (RD), Dietary Manager, Resident-Assessment-Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents, and family members.

The inspector also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident System (CIS) report was submitted to the Director related to allegations of staff to resident abuse. The CIS report indicated that the spouse of resident #002 observed PSW #118 act inappropriately and this was reported to ADOC #120.

The Inspector reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program" (RC-02-01-01) last updated April 2017, which indicated that all residents were to be protected from all forms of abuse at all times.

During an interview with the Inspector on October 13, 2017, resident #002's spouse stated that they overheard PSW #118 make inappropriate comments and observed PSW #118 act inappropriately.

In a telephone interview with the Inspector on October 13, 2017, PSW #118 acknowledged that they acted inappropriately. PSW #118 stated that they acted in this manner because a resident was not feeling well and the resident's mood was down.

In an interview with the Inspector, the home's Administrator stated that they did not believe that PSW #118's actions were appropriate; however, they could not comment further on the situation because they had not yet had the opportunity to fully investigate the incident.

2. During the interview with the Inspector on October 13, 2017, resident #002's spouse stated that they had reported what they observed, to PSW #117 on the date that the incident occurred.

The Inspector reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) last updated April 2017, which indicated that anyone who witnessed or suspected abuse or neglect of a resident must

notify management immediately.

In an interview with the Inspector on October 13, 2017, PSW #117 stated that resident #002's spouse reported to them that they had overheard PSW #118 make inappropriate comments and observed PSW #118 act inappropriately.

In an interview with the Inspector, the home's Administrator stated that if a visitor told a member of the home's staff that they observed another staff member acting inappropriately, this information should have been immediately reported to management so that an investigation could have been immediately initiated.

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's written policy to promote zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

Issued on this 26th day of October, 2017

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

Original report signed by the inspector.