Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Aug 7, 8, 9, 16, 17, Sep 6, 7, 2012	2012_140158_0012	Mandatory Reporting

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered staff, Personal Support Workers (PSWs), the Quality Assurance Co-ordinator, Activity aides, and residents.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident interactions and care, reviewed health care records, policies and procedures and staff education/training records.

The following inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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. Staff #100 has been implicated in three separate episodes of alleged resident abuse.
The home submitted a Critical/Mandatory Incident identifying that staff # 100 allegedly grabbed resident # 01 by the throat and ripped off the medicated patch. The home investigated the incident and staff # 100 was re-assigned to other floors where there were fewer cognitively impaired residents.
The home submitted a second Critical/Mandatory Incident which identified that staff # 100 allegedly inappropriately touched a female resident in the genital area. The female resident was assessed as being moderately cognitively impaired.
The Inspector was informed of the third episode on August 8/12 when the Administrator and DOC identified that a past allegation of verbal abuse by staff # 100 towards resident # 05 was investigated and not substantiated.
The health care record including the plan of care for resident # 01 was reviewed by the Inspector on August 3/12. The progress notes identified that it was alleged that " a big tall person came into the resident's room and put their hands around resident # 01 neck". It was identified that resident # 01 was agitated and yelling. It was also documented that the resident's neck had petechia and that the resident was guarding the neck area when the RN attempted to assess the area. The RN reported to the DOC that the resident was frightened. Fear and agitation and subsequent interventions were not identified in the plan of care. Staff # 110 identified that resident #01 still has periods of agitation.
Resident # 01 was guarded and appeared agitated when the Inspector approached the resident on Aug 7/12.
The health care record including the plan of care for resident # 02 was reviewed by the Inspector on August 7/12. Entries regarding the alleged sexual abuse incident were not found in the progress notes, in the 24-hr report book or in the doctor's book.
The Inspector spoke with staff # 102 who showed the Inspector the written notes of the event and was directed not to document in the resident's health care record by management. The Inspector spoke with staff # 107 and staff # 109 who identified that they were not aware that incident occurred. Staff # 116 identified that they became aware of the incident on August 6/12 when the resident informed them.
On Aug 7/12 at 1330hr, the Inspector spoke with resident # 02. The resident was able to answer questions as per MOHLTC protocol and was assessed as being able to be interviewed. The resident was poignant and able to recall the events of the incident with clarity. When questioned how they felt regarding the incident, the resident responded, " I feel dirty and ashamed". Interventions to manage the feelings of unworthiness and shame were not identified in resident # 02 plan of care.
The health care record including the plan of care for resident # 05 was reviewed by the Inspector on August 7/12. There were no entries found in the June/July/August/12 progress notes identifying that the alleged verbal abuse occurred, however, resident # 05 identified to the Inspector on August 2/12 that there was a staff member who spoke harshly and made resident # 05 feel uncomfortable. Resident # 05 did express that they did not want this staff member to care for them. Interventions to manage the resident's anxiety and fear related to the care provided by the employee was not identified in the plan of care.
The DOC confirmed that Staff # 100 worked on the units where resident # 01, resident # 02 and resident # 05 resides.
The Inspector interviewed several Registered staff on August 7/12 and August 8/12 and they were not aware that staff # 100 performance needed to be monitored.
The employee records for Staff # 100 were reviewed by the Inspector on August 7 and 8/12. The record is void of any reference to the three allegations of abuse.
The "abuse" in-service attendance list held on January/12 identified that staff # 100 attended the session. There were no records found that staff # 100 attended further abuse sessions after the first incident. Staff # 100 was called by the home and informed to not report to work for two weeks as per police direction.
The home has not protected the residents from abuse by anyone. [LTCHA 2007, S.O. 2007. c.8, s. 19 (1)]

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 ensuring that all residents in the home are protected from abuse by anyone, 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. When resident # 03 was sitting in the dining room watching TV, resident # 04 forcefully took the remote out of resident # 08 hands. Resident # 03 stated to the RN that they wanted to press charges against resident #04. The administrator met with resident # 03 and identified that resident # 04 wanted to apologize which resident # 03 declined. The progress notes identified that resident # 03 required comforting strategies post incident. There was no further documentation regarding the incident in the progress notes. Resident # 03 identified to the inspector on August 3, 7 and 8/12 that they still wanted to press charges and remains fearful of resident # 04. The home did not immediately report the suspicion of emotional abuse by resident # 04 to resident # 03 to the Director: [LTCHA 2007, S.O. 2007, s. 24. (1) 2]

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 ensuring that all incidents of abuse are reported immediately to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The Inspector was in the home at 06:00hr and observed that Staff S-018 was working the night shift on August 8/12. Staff S-018 employed by a contracted agency informed the inspector that this was their first shift in the home. When questioned by the Inspector as to the orientation received prior to working this shift, the Staff # S-018 identified that they did not receive orientation in Resident Rights, or the following home policies; duty to report under section 24, fire, abuse, restraining or emergency policies. Staff S-018 also stated that an orientation package was not received prior to working this shift.
It was confirmed by the scheduler that Staff S-018 was scheduled to have a 4-hr orientation prior to working the 23:30-07:30 night shift on August 8/12.
The inspector spoke with the Administrator, Staff S-014 and Staff S-015 regarding the orientation of agency staff on August 8/12. It was identified by Staff S-014 that an 8-hr comprehensive orientation was provided to the agency staff in March/12. The orientation package used for this orientation session was reviewed by the Inspector and contained the legislative requirements. The attendance sheet for the March/12 orientation session was reviewed and Staff S-018 was not on this list. There was no documentation provided the Inspector to identify what S-018 was oriented to on August 7/12.
Staff S-015 identified that the RN who orientates agency staff ensures that documentation in point click care, E-MARS, E-TARS, resident meal service, equipment availability, on call list for managers and physicians, infection control, location of manuals and the home's zero-lift policy is reviewed during this 4-hr blitz.
The home did not ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training.

Issued on this 7th day of September, 2012

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