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

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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
Jul 23, 2014	2014_283544_0018	S-000196, 205-14	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 FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

FRANCA MCMILLAN (544)

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): June 23, 24, 25, 2014 related to

Log # S- 000205-14
Log # S- 000196-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director's of Care (ADOCs), Risk Management Co-ordinator, Registered Staff, Personal Support Workers (PSWs), Residents, and Families.

During the course of the inspection, the inspector(s) observed daily the delivery of care and services to the residents, staff to resident interactions, reviewed the policy regarding Prevention of Abuse/Neglect, staff education and attendance records regarding this policy, the policy related to Prevention and Infection Control, Managing an Outbreak, the staff education and staff attendance records regarding this policy.

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

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. 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 Director was notified of an allegation of resident abuse by a staff member.

Inspector # 544 reviewed the Staff to Resident Abuse Policy, Policy Reference # OPER -02-02-04 Version November 2013. Policy states: "There is zero tolerance of abuse towards a Resident."
"Resident abuse will result in termination."

Inspector # 544 interviewed Staff # 100 and Staff # 101 and they confirmed that although the policy states, "Resident abuse will result in termination", it was decided, in consultation with the Corporate Lawyer for the home and the Union Representative, that Staff # 108 be given a suspension without pay, due to a long and committed service to the home and Residents and this being their first discipline on record. The Employee was moved to work on another resident care unit and was re-educated in the Residents' Bill of Rights, Extendicare Canada Inc. Abuse Policy and the Employee Code of Conduct.

Staff # 100 and Staff # 101 confirmed that they will contact Extendicare Corporate Office in Toronto, in regards to the policy statement of, "Resident abuse will result in termination." The last revision for the Prevention of Abuse policy was November 2013.

The licensee failed to ensure that the Abuse Policy is complied with. [s. 20. (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 to ensure that the written policy that promotes zero tolerance of abuse and neglect of the residents is complied with, 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 :

1. Inspector # 544 reviewed Critical Incident Report where the Director was notified of an allegation of Resident abuse by a staff member.
The home conducted their own investigation and called the Police to investigate further.

According to the Staff # 100 and Staff # 101 the Police Officer told them that this was an internal matter and the home could deal with the situation on their own.
The home conducted an internal investigation and interviewed the staff member involved in the incident and Resident # 002.

Staff # 100 and Staff # 101 confirmed that they did not notify the Director immediately in this situation as they felt it was not a case of abuse since the police told them that it was an internal matter and could be resolved internally and no criminal charges were laid.

The licensee failed to report immediately to the Director suspicion of abuse of Resident # 002 by Staff # 108. [s. 24. (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 to ensure that any person who has reasonable grounds to suspect abuse of a resident by staff, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. Inspector # 544 reviewed a Critical Incident report.

The home reported in May that there was a Respiratory Outbreak involving nine (9) Residents in the home on a care unit.
The Public Health declared a Respiratory Outbreak.
One Resident was identified to be positive for Influenza B.

The home did not report this outbreak of a reportable disease to the Director immediately.

Inspector # 544 interviewed Staff # 103 who confirmed that this outbreak was not reported to the Director immediately.

The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstance of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. [s. 107. (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 to ensure that the Director is informed immediately, in as much detail as possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined by the Health Protection and Promotions Act, to be implemented voluntarily.

Issued on this 24th day of July, 2014

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