Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2020	2020_689586_0020	017095-20	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Hamilton
90 Chedmac Drive HAMILTON ON L9C 7S6

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

JESSICA PALADINO (586)

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): September 15 and 16, 2020.

The following Critical Incident Inspection (CIS) inspection was completed: 017095-20 regarding resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Hamilton Police, Staffing Agency, residents and staff.

During the course of the inspection, the inspector(s) toured the home, reviewed resident health records ,relevant policies and procedures, internal investigation notes, employee files, training materials and education records.

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.
- **2 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	Légende 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. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that police record checks were conducted prior to hiring staff.

LTCHA, s. 2 (1) defines "staff" as persons who work at the home as employees of the licensee, pursuant to a contract or agreement with the licensee or pursuant to a contract or agreement between the licensee and an employment agency or third party.

An emergency order was put into place March 27, 2020, under the Emergency Management and Civil Protection Act, s. 7.0.2 (4), declaring that, "Licensees are not required to meet the screening measures set out in the LTCHA and Ontario Regulation 79/10 provided that they adopt other measures that ensure resident care and safety."

Resident #001 reported an allegation of abuse by a staff member in the home. The DOC and staffing agency confirmed that both parties did not have a copy of the staff member's police record check, and no other measures were adopted to ensure resident care and safety.

Sources: the home's internal investigation notes, one of the home's policies, interview with the DOC and staffing agency. [s. 75. (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 to ensure screening measures including police record checks are completed upon hire, to be implemented voluntarily.

WN #2: 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:

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. The licensee has failed to ensure that resident #001 was protected from abuse by a staff member.

The following is further evidence to support the order issued on August 25, 2020, during inspection 2020_587129_0006 to be complied by December 18, 2020.

Ontario Regulation 79/10 provides definitions for different types of abuse. Resident #001 reported an allegation of abuse by a staff member. The resident's recollection of the incident remained consistent while describing what happened to multiple parties. While speaking with the LTCH Inspector, the resident stated that they remained fearful.

Resident #001 was not protected from abuse by a staff member.

Sources: CIS #2858-000014-20, the home's internal investigation notes, the resident's electronic health record, one of the home's policies, interviews with resident #001, DOC and an external party. [s. 19. (1)]

Issued on this 2nd day of October, 2020

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

Original report signed by the inspector.