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
Jun 1, 2016	2016_391603_0008	009771-16	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 KIRKLAND LAKE
155 GOVERNMENT ROAD EAST P.O. BAG 3900 KIRKLAND LAKE ON P2N 3P4

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

SYLVIE LAVICTOIRE (603)

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): May 11, 2016

This Critical Incident inspection is related to 2 critical incidents the home submitted related to allegations of abuse to a resident.

A follow up inspection was conducted concurrently with this inspection. For details, see inspection #2016_391603_0009.

During the course of the inspection, the Inspector directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies and procedures, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses, Personal Support Workers, and Residents.

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 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. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

1. Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI related to alleged staff to resident abuse; whereby, RPN #103 disrespected and yelled at resident #001 when the resident asked for care.

A review of the home's investigation notes revealed that when the incident of staff to resident abuse happened, RN #102 reported the incident to the DOC on that same day; however, the DOC did not report this incident to the Director until the next day.

An interview with the DOC confirmed that she did not report the alleged abused until the next day and explained that this was "an oversight of my part". The DOC also explained that in these circumstances, the staff are to call the administrator on call, who will then report the incident of alleged abuse to the Director immediately.

A review of the home's current Mandatory and Critical Incident Reports Policy revealed that the DOC or designate will inform the MOH Director immediately, in as much detail as possible, in the circumstances of 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.

2. Inspector #603 reviewed a Critical Incident Report submitted to the Director. The CI related to alleged staff to resident abuse; whereby, a staff member verbally disrespected resident #001.

On a specific date, Inspector #603 interviewed resident #001 who explained that approximately 2 weeks prior, a staff member had found out that the resident was once again smoking. While the resident was with other residents in sight, the staff member said to the resident: "What are you trying to do? Commit suicide slowly?" This made the resident very upset and told the staff member that they did not like her talking to them this way. The staff member stated: "Well, think about it." The resident also explained that they had informed RPN #106 and they had suggested that the resident report this abusive conduct; however, the resident decided not to.

A review of the home's investigation notes revealed that once the Administrator and the Director of Care approached the staff member with the alleged verbal resident abuse, the staff member apologized to the resident for speaking to them in a manner they did not like.

An interview with the Administrator and the DOC revealed that it was the home's expectation that the RPN should have reported the alleged abuse to the DOC or to the Director.

A review of the home's current Zero Tolerance of Resident Abuse and Neglect Policy revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate /reporting manager or if unavailable, to the most senior Supervisor on shift at that time. In addition to the above, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident, misappropriation of funds is required to contact the MOHLTC (Director) through the Action Line and is protected by legislation for retaliation. [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 the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff resulting in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 6th day of June, 2016

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

Original report signed by the inspector.