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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2017	2017_627138_0020	013840-17	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 LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

PAULA MACDONALD (138)

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): July 5 and 6, 2017.

This inspection related to Critical Incident Report #2665-000057-17, alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, the Front Receptionist, a registered nurse (RN), and personal support workers (PSW).

The inspector also reviewed internal investigation documents, a resident health care record, employee training records, and the home's policies for zero tolerance of abuse and neglect of 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)**
- **0 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 comply with section 20.(1) of the Act in that the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents that is in place is complied with.

The home submitted a Critical Incident Report (CIR) to the Director of the Ministry Health and Long Term Care regarding an incident of alleged staff to resident abuse.

Inspector #138 reviewed the home's internal investigation documents which demonstrated that PSW #100 became aware of an incident of alleged physical abuse to resident #001 by PSW #103. Inspector #138 spoke with PSW #100 who stated to the inspector that she had became aware of the incident of alleged abuse to resident #001 when, according to her, PSW #101 reported to her in the home on a specific date and time that she had witnessed physical abuse to resident #001 by PSW #103. PSW #100 further stated that she called RN #104 later to discuss the incident.

Inspector #138 also spoke with RN #104 who confirmed that PSW #100 called her at her personal residence on the evening of the specified date, to report that she was approached by PSW #101 earlier that day while working with an incident in which she witnessed PSW #103 being physically abusive with resident #001. RN #104 stated that she reported the incident first thing the next day when she arrived at the home for shift.

Inspector #138 was provided the home's abuse policies related to zero tolerance of abuse and neglect of residents. The inspector noted that the policy, Resident Abuse - Staff to Resident, outlined that all staff are to immediately report any suspected or witnessed abuse to the Administrator, Director of Care or their designate.

As such, the licensee did not comply with its policies of zero tolerance of abuse and neglect of residents in that PSW #100 failed to immediately report alleged physical abuse of resident #001 to the Administrator, Director of Care or their designate immediately when becoming aware on a specified date and time. [s. 20. (1)]

Issued on this 7th day of July, 2017

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

Original report signed by the inspector.