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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2018	2018_617148_0029	002480-18, 002735-18, 003818-18, 003892-18, 003895-18, 004663-18, 005919-18, 006215-18, 006580-18, 006886-18, 008560-18, 011858-18, 025876-18	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 Laurier Manor
1715 Montreal Road GLOUCESTER ON K1J 6N4

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

AMANDA NIXON (148), LYNE DUCHESNE (117), MEGAN MACPHAIL (551)

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): October 1-4, 9-12 and 15-17, 2018

This inspection included thirteen logs involving critical incident reports (CIR) including: Logs 002480-18 (CIR 2665-000008-18), 002735-18 (CIR 2665-000009-18), 003895-18 (CIR 2665-000020-18), 005919-18 (CIR 2665-000029-18), 006215-18 (CIR 2665-000030-18), 006580-18 (CIR 2665- 000032-18), 006886-18 (CIR 2665-000037-18) and 011858-18 (CIR 2665-000057-18) related to resident to resident alleged sexual abuse; Logs 003818-18 (CIR 2665-000022-18) and 008560- 18 (CIR 2665-000042-18) related to staff to resident alleged physical abuse; Logs 003892-18 (CIR 2665-00019-18) and 004663-18 (CIR 2665-000025-18) related to resident alleged physical abuse; and Log 025876-18 (CIR 2665-000080-18) related to an unknown injury.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Assistant Director of Care, Quality Care Manager, Scheduling Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Office Manager, Food Service Supervisor, Administrative Assistant and residents.

The Inspectors reviewed the health care records of identified residents, documents related to the licensee's investigation into reported incidents, along with pertinent program policies, as applicable, including the policy to promote zero tolerance of abuse and neglect of residents. In addition, the Inspectors observed resident care and services, the resident's environment, staff to resident interactions and resident to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.

3 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the results of every abuse or neglect investigation were reported to the Director.

A critical incident report (CIR) was submitted to the Director on a specified date, to report an allegation of staff to resident abuse.

The CIR describes that on a specified date, resident #014 reported to the resident's substitute decision maker (SDM) that PSW #128 was rude to the resident and not gentle during the provision of care on an identified shift whereby a minor injury was sustained. The SDM then informed RN #127 of the allegation.

Approximately three weeks later the licensee completed their investigation and could not determine if the abuse had occurred.

In review of the CIR the results of the licensee's investigation were not reported to the Director.
(Log 008560-18)

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 :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg 79/10, section 2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date, the home submitted a critical incident report to the Director describing that two days prior, resident #004 was observed touching resident #005 in a sexual nature. The residents were separated along with additional actions including behavioural mapping. The health care record and staff interviews support that the evening RPN #104 and RN #101 were made aware of the incident on the date the incident occurred; RN #101 reported the incident to the on call manager #108. Direction from Manager #108 included to follow steps for reporting.

Two days after the incident, RN #102 completed an incident report; the substitute decision makers for the identified residents were informed of the incident; and a report was submitted to the Director by the home's DOC.

In discussion with RN #101 and Manager #108 it was reported that the registered nursing

staff are responsible to contact the Director outside of business hours, through the after-hours pager number. RN #101 reported to the Inspector that at the time of the incident it was unclear to RN #101 if the incident was abuse, as the touch described was not a grab; in this way it was unclear to RN #101 if the incident constituted abuse.

On a specified date, the home submitted a critical incident report to the Director describing that on the previous day, resident #004 was observed touching resident #005 in a sexual nature. The residents were separated along with additional actions including one to one monitoring and urine culture and sensitivity. The health care record and staff interviews support that the evening RPN #104 and RN #119 were aware of the incident on the date the incident occurred.

The day after the incident, RN #103 completed an incident report; the substitute decision makers for the identified residents were informed of the incident; and a report was submitted to the by the home's DOC.

The licensee did not ensure that the Director was informed immediately of two incidents of alleged sexual abuse.
(Log 002480-18 and 002735-18)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specified day resident #004 was observed touching resident #005. Two days later, the substitute decision makers for the identified residents were informed of the incident.

On a specified date resident #004 was observed touching resident #005. The next day the substitute decision makers for the identified residents were informed of the incident.

The licensee did not ensure that the resident's substitute decision-maker was notified within 12 hours of an alleged sexual abuse.
(Log 002480-18 and 002735-18)

Issued on this 23rd day of October, 2018

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

Original report signed by the inspector.