Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: September 14, 2023	
Inspection Number: 2023-1171-0004	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Laurier Manor, Gloucester	
Lead Inspector Margaret Beamish (000723)	**Inspector Digital Signature** Margaret E Beamish Digitally signed by Margaret E Beamish Date: 2023.09.15 11:03:05 -04'00'
Additional Inspector(s) Pamela Finnikin (720492) Saba Wardak (000732)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 16-17, 21-23, 2023
The inspection occurred offsite on the following date: August 18, 2023

The following intakes were inspected in this Critical Incident (CI) inspection:

Alleged staff to resident abuse:
- Intake #00089533
- Intake #00091948
- Intake #00092666

Alleged resident to resident abuse:
- Intake #00094091

Fall with injury resulting in a significant change in condition:
- Intake #00091881

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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

Rationale and Summary

#1

On an identified date, an Assistant Director of Care (ADOC) received separate emails from two staff members containing allegations of verbal abuse towards a resident by a staff member.

A review of the licensee's investigation file and Critical Incident Report (CIR) noted that the allegations of abuse were not reported to the Director until the day after the staff of the home were made aware. This was confirmed in an interview with an ADOC.

Failing to immediately report allegations of abuse to the Director, may delay the investigation placing residents at risk of harm.

Sources: CIR, licensee investigation file and interview with an ADOC. [000723]

#2

On an identified date, a Registered Practical Nurse (RPN) documented in a resident's chart two witnessed incidents of alleged sexual abuse towards another resident.

An Investigation form stated that a few days later, an Assistant Director of Care (ADOC) was reviewing the resident's progress notes and discovered the incident that had occurred.

A Critical Incident Report (CIR) was submitted to the Director the day the ADOC read the resident's progress notes to report the incident of alleged sexual abuse that had occurred a few days before. The witnessed incident was not immediately reported to the Director.

In an interview with the ADOC, they confirmed that the Director was not notified of the incident immediately.

Failing to immediately report allegations of abuse to the Director, may delay the investigation placing residents at risk of harm.

Sources: Resident progress notes, internal investigation form, CIR, and interview with an ADOC. [720492]

WRITTEN NOTIFICATION: Police notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged abuse of a resident.

Rationale and Summary
On an identified date, an Assistant Director of Care (ADOC) received separate emails from two staff members containing allegations of verbal abuse towards a resident by a staff member.

A review of the licensee’s investigation file and the Critical Incident Report (CIR) noted that the staff of the home were made aware of the allegations of verbal abuse on a certain date. The unusual occurrence form dated for the following day from the licensee’s internal investigation file, stated that the police

were not notified of the allegations of verbal abuse. In an interview with an Assistant Director of Care (ADOC), they confirmed it is the expectation that the police be notified when responding to allegations of abuse and that the charge nurse working on that day, did not immediately notify the police.

Failing to immediately notify the police service of alleged abuse may delay the investigation and places residents at risk of harm.

Sources: CIR, licensee investigation file, unusual occurrence form, and interview with an ADOC. [000723]