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

London District
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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: October 2, 2024
Inspection Number: 2024-1055-0003
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare London, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19, 23 to 25, 2024

The following intake(s) were inspected:

- Intake: #00117844 -CIS 2173-000018-24 - Allegation of abuse.
- Intake: #00124423 -CSI-2173-000023-24 - Respiratory outbreak.
- Intake: #00124751 -CIS-2173-000024-24 - Respiratory outbreak.
- Intake: #00125556 -CIS-2173-000025-24 - Improper/Incompetent treatment of resident by staff for plan of care.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance to Abuse & Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary:

A Critical Incident System (CIS) report was received by the Director related to alleged staff-to-resident abuse.

The CIS report indicated that Personal Support Worker (PSW) witnessed two incidents of alleged staff to resident abuse however reported the incident to the home's management team after three days. The home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy states that at minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately.

PSW confirmed that they did not immediately report the witnessed physical and verbal abuse despite being aware of the LTCH's policy to report any abuse immediately.

Home's management team confirmed that staff should have immediately reported the incident to management. Their investigation of the incident found that staff failed to comply with the

home's policy of immediately reporting resident abuse and neglect.

When the staff did not immediately report the incident, as required by the home's zero-tolerance policy for abuse and neglect, it created a risk that the incident might not be promptly investigated, and necessary actions might not be taken in response.

Sources:

Review of the CIS report submitted by home , the home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy RC-02-01-02 ,home's Workplace Investigation Summary of the incident, and interviews with staff and management team members.