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
Sep 27, 2016	2016_200148_0031	024231-16, 024601-16	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 MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

AMANDA NIXON (148)

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): September 12, 13 and 14, 2016

This inspection included two critical incidents, one related to a fall with injury and a second related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Assistant Director of Care (ADOC), Support Service Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers and residents.

The Inspector also reviewed resident health care records, documents related to the incident of alleged abuse and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

In accordance with O.Regulation 79/10, s.2(1), physical abuse means, the use of physical force by a resident that causes physical injury to another resident and emotional abuse means any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

A critical incident was reported by RN #100, to the Director/MOHLTC on specified date, through the after hours pager system. The report described the alleged physical abuse of resident #002, whereby resident #001 had hit resident #002 with a physical device causing an injury to resident #002. The report also alleged that resident #004 had also been hit by resident #001 with the same physical device, injuries were not specified for this resident.

Based on interviews, review of resident health care records and documentation maintained by the home related to the report of alleged abuse, the sequence of events was as follows:
-On a specified date during the evening shift on a weekend, resident #002 contacted the

local police force to disclose that an incident had occurred in a specified area of the home.
-RN #100 received a call from the local police force and then proceeded to ensure that resident #001 and #002 were separated and safe. In an interview with the Inspector on September 13, 2016, RN #100 indicated that resident #001 was unwilling to answer questions about the incident and interviews with resident #002 indicated that resident #001 had hit resident #002 with the identified physical device. During the interview she recalls having also assessed resident #004, as this resident claimed that resident #001 hit him/her on the back with a physical device. RN #100 reported to the Inspector that no injuries were found on either of the residents examined.
-On the same evening of the incident, RN #100 contacted the Support Services Manager #101, who was the scheduled on-call manager that weekend. In an interview with the Inspector, Manager #101 stated that it was reported to him that resident #001 hit resident #002 with a physical device and that resident #002 had suffered injury. An incident report completed by RN #100 indicates an injury to resident #002, injury specified as "other".
-RN #100 contacted the Director/MOHLTC, as described above, in addition to speaking with the appropriate substitute decision makers (SDM) / family members for resident #001 and #002.
-RN #100 reported to the Inspector that safety checks were initiated for resident #001 to monitor for any further aggression. The incident was then communicated to the night shift and proceeding day shift nursing staff.
- During interviews with RN #102, RN#103 and RPN #104, who were working the day shift on the day following the incident, it was demonstrated that various facts of the events had circulated including that either or both resident #001 and/or #004 had been the aggressors, with monitoring occurring informally of resident #001 and/or resident #004.
- On the first business day after the incident, two days after the incident, Manager #101 reported the alleged incident of abuse to the home's management team during the home's morning management meeting, of which the home's ADOC was in attendance.
- On that same day, the home's ADOC initiated the investigation which included resident interviews and health care record review. During an interview with the Inspector, the ADOC indicated that the resident interviews lead her to believe that the original facts of the incident may be in question.
- On the following day, the ADOC reviewed video footage which captures the home area where the incident occurred. The ADOC reported to the Inspector, that it was after the video was reviewed that it became clear that resident #002, #003 and #004 appeared to have a verbal and physical altercation with resident #001, whereby resident #002, #003 and #004 were the aggressors. The home updated the residents involved who were

believed to be capable, appropriate family members and the local police force with the conclusion of the investigation.

During an interview with the Inspector, the Support Services Manager #101 reported that his actions included providing support and guidance to RN #100 and speaking to the SDM of resident #002 who was upset by the incident. He reported that his actions taken on the weekend of the incident did not include the initiation of an investigation into the alleged abuse.

The lead of the licensee's investigation was identified to be the home's ADOC. In an interview, the ADOC stated that actions to investigate the incident began two days after the incident had occurred.

The licensee failed to ensure that the incident of alleged abuse that occurred between resident #001, #002, #003 and #004, was immediately investigated. [s. 23. (1) (a)]

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 to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

Issued on this 27th day of September, 2016

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

Original report signed by the inspector.