Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 9, 2020	2020_618211_0008	000893-20, 003142-20, 003608-20	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 Medex
1865 Baseline Road OTTAWA ON K2C 3K6

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

JOELLE TAILLEFER (211)

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): February 24, 25, 28, 2020 and March 2, 3, 4, 5, 2020.

The following logs were inspected:
#003608-20 related to unexpected death.
#003142-20 and #000893-20 related to two different types of alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), a Physician, Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Social Worker, Personal Support Workers (PSWs), including residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, residents' environment and reviewed resident health care records, staffing education, Medex Fall and Winter Menu, letters from a family member and the policy related to Zero Tolerance of resident Abuse and Neglect Program.

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.
- **2 WN(s)**
- **2 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	Légende 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. 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 :

1. The licensee failed to ensure when 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:
4. Misuse or misappropriation of a resident's money.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report, related to suspicion of an identified abuse from a family member toward resident #007. The CIS indicated that on an identified date, resident #007's family member called the Social Worker #114 and resident #007 requesting a specific amount of money for personal needs. When resident #007 was questioned by the Social Worker related to the family member asking for the identified help, resident #007 expressed feeling sorry for the family member and wishing to give the amount requested. The next day, Social Worker #114 received a second call from resident #007's family member stating that the resident had cognitive impairment and was unable to make decisions regarding a specific choice.

Review of the Social Worker #114's notes written on an identified date, indicated that an application for an identified assessment was required for resident #007 since the resident's family member expressed that the resident was unable to make a decision related to a specific choice. The Social Worker #114's note indicated suspecting an identified abuse after a discussion with the resident's family member on that identified date.

In an interview with the Social Worker #114 on an identified date, they stated that the Ministry of Long-Term Care was not notified immediately related to the suspected identified abuse from resident #007's family member as the process to report was not understood. The Social Worker #114 indicated that the CIR should have been forwards to the Director on the identified date, when suspecting the identified abuse from resident #007's family member. [s. 24. (1)]

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 when a person who has reasonable grounds to suspect that any misuse or misappropriation of a resident's money has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

As outlined in WN #1 a review of the Social Worker #114's notes written on an identified date, indicated suspecting an identified abuse after having a discussion with resident #007's family member.

In an interview with the Social Worker #114 on an identified date, and review of the Social Worker #114's notes indicated that they contacted the police force fourteen days after they suspected the identified abuse.

The licensee has failed to ensure that the appropriated police force was immediately notified on the identified date, when the Social Worker #114 suspected the identified abuse from a family member towards resident #007. [s. 98.]

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 the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence., to be implemented voluntarily.

Issued on this 10th day of March, 2020

[redacted]

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

Original report signed by the inspector.