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

Toronto District
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Original Public Report

Report Issue Date: December 16, 2022	
Inspection Number: 2022-1369-0003	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Mississauga, Mississauga	
Lead Inspector Waseema Khan (741104)	**Inspector Digital Signature** Waseema Khan Digitally signed by Waseema Khan Date: 2022.12.29 12:57:12 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 2, 5, 6, 7, 8 and 9, 2022

The following intake(s) were inspected:

- Intake: #00005556 Alleged staff to resident abuse

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

Prevention of Abuse and Neglect
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that resident was provided care as specified in the plan.

Rationale and Summary

RPN and PSW provided peri-care and change of incontinent product to resident in their room.

RPN told the resident that they were there to provide care. Resident told the RPN that the water temperature was cold twice. After RPN changed the water to warmer water one time, they proceeded to provide care.
During an incontinent product change, resident was being verbally and physically resistive to care. A Stop and Go approach was not used which was indicated in the resident's plan of care.

RPN acknowledged that they did not use the Stop and Go approach as indicated in the resident's written care plan when they continued to provide care while the resident was upset.

Specifically, staff did not comply with the strategy to use Stop and Go approach as per plan of care.

Sources: Education material: STOP and GO Approach Dealing with Dementia Behaviors.
Resident's clinical records; interviews with RPN, Administrator, ADOC, BSO, and other staff.

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

Rationale and Summary
During morning care RPN and PSW continued to provide care when the resident was upset.
As a result of this interaction RPN tried to stop them from physically resisting care. RPN acknowledged that they continued to provide care to the resident. Resident disclosed that this incident had occurred.
During the next shift, resident reported to RN that night staff mishandled them.

RN verified that resident had informed about the incident, but they did not report it to the manager immediately as per the home's policy. They reported it to ADOC the next day.
Administrator confirmed that RN did not comply with the home's zero tolerance of abuse and neglect policy when they did not report it immediately and did not take action.

There was a moderate risk of harm to the resident when staff did not comply with the home's policy.

Sources: Resident's clinical records; Zero Tolerance of resident Abuse and Neglect program RC 02-01-01 Last reviewed: January 2022. Interviews with RN, Administrator, and ADOC.

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