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

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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
Oct 6, 2016	2016_293554_0019	027271-16, 027273-16, 027275-16	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 OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

KELLY BURNS (554)

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 12-14, 2016

Intakes reviewed and inspected: #027271-16, 027273-16 and 027275-16.

Summary of Intakes:
1) 027271-16 - Critical Incident Report (CIR) - witnessed incident of resident to resident sexual abuse;
2) 027273-16 - CIR - witnessed incident of resident to resident sexual abuse;
3) 027275-16 - CIR - allegation of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, RAI-C, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behaviour Supports Lead, Family and Residents.

Also during the course of this inspection, the inspector, toured the home, reviewed clinical health records, observed staff to resident interactions, and resident to resident interactions, reviewed home's investigational notes, and policies of the organization, specifically Zero Tolerance of Abuse and Neglect, Responsive Behaviours, Responsive Episode Debriefing, and Critical Incidents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, specific to responsive behaviours.

Related to Intake #027271-16, 027273-16, and 027275-16, all relating to Resident #001:

Resident #001 has a history which includes cognitive impairment.

Personal Support Workers (PSW) #054, and #055, Registered Practical Nurse (RPN) #053, Registered Nurse #051 and the Director of Care, all indicated resident #001 has known responsive behaviours, which include inappropriate non-consensual touching of co-residents, and sexual expressions directed towards co-residents, staff and self.

The clinical health record, for resident #001, was reviewed for an identified period of time.

The written plan of care (currently in place) identifies:
- Mood State, repeats self, sad, worried. Interventions include, identifying root cause and to identify strategies to address;
- Responsive behaviour, specifically listed are, wandering, refusing care, socially inappropriate, sexual inappropriateness.
Interventions include, stuffing envelopes and putting stickers like stamps on them, offering sweets as a distraction, use of music and television programs, 1:1 supervision in place, and verbal cues to help resident locate his/her room.

During this review (dates indicated above) the following was documented within progress notes, by registered nursing staff and or personal support workers:
- Resident #001 was observed, by staff, exhibiting specific responsive behaviours, within his/her room. As per progress notes, Personal Support Workers (PSWs) tried to redirect residents actions; actions taken by staff included, closing door, providing privacy, telling resident what he/she was doing was inappropriate, to stop it, and telling resident to remove his/her hand and to go to sleep.
- Resident #001 asked direct care staff, to "get into bed with him/her" and to "join him/her in the shower"; resident, was observed (by PSW's), exposing self to care staff and those passing in the hallway. According to the progress notes, direct care staff tried to verbally redirect the resident or other times staff would leave the resident's room.

Personal Support Worker #054, who was assigned to care for resident #001, during dates of this inspection, indicated being unclear as to what he/she is to say or actions he/she is to take when resident #001 is observed exhibiting the said responsive behaviours, as there is no clear direction to guide him/her when interacting with the said resident.

The written plan of care for resident #001 fails to provide clear directions to direct care staff, as to actions to be taken, when resident is exhibiting sexually inappropriate and or sexually expressive responsive behaviours. [s. 6. (1) (c)]

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 there is a process in place and monitored, ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

Related to Resident #006:

The home's policy, Zero Tolerance of Abuse and Neglect (#RC-02-01-01 and #RC-02-01 -02) states that Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity, and respect and protected from all forms of abuse. Verbal abuse, in this policy, is described as inappropriate tone, abusive language, yelling, rude, and offensive comments. The policy directs that all staff will protect, detect and immediately respond to any alleged or suspected incident of resident abuse. All abuse, alleged, suspected or witnessed will be reported to the Administrator.

Resident #006 reported an incident to the Director of Care on an identified date, alleging Registered Practical Nurse (RPN) #052 yelled at him/her on two occasions.

The Director of Care acknowledged being aware of the allegation and provided the inspector with witness statements by resident #006 and a visitor, both are dated on an identified date.

The Administrator indicated "yelling by staff at a resident would be considered a form of abuse".

The Administrator indicated "not being aware of the alleged incidents", and added "the alleged incidents should have been reported to her based on the home's policy". [s. 20. (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 there is a process in place and monitored, ensuring the written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #3: 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 that 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, specifically, abuse of a resident by anyone.

Related to Resident #006:

Resident #006 is cognitively well.

During this inspection, resident #006 stated to the inspector, that Registered Practical Nurse (RPN) #052 had yelled at him/her, twice, on an identified date. Resident #006 indicated the yelling by RPN #052, "occurred in the lounge and later the same shift in my room". Resident #006 indicated "it upset me that RPN #052 yelled at me; I cried all night".

Resident #006 indicated that he/she reported the incident to the Director of Care.

The Director of Care (DOC) acknowledged that resident #006 had reported, to her on a specific date, being yelled at by RPN #052. DOC indicated being aware that resident #006 was upset by the alleged actions of RPN #052.

The Director of Care indicated the interaction between resident #006 and RPN #052 was witnessed by a visitor of the home, and indicated that "the visitor commented that the observed interaction was inappropriate, as RPN #052 should not have yelled at resident #006". DOC indicated "the visitor said that resident #006 was also yelling at the RPN".

The Director of Care indicated "yelling by staff at a resident, could be seen as abusive".

The Director of Care indicated that the alleged staff to resident verbal abuse had not been reported to the Director, as defined by the Long-Term Care Homes Act, as she did not believe the incident happened as resident #006 described it, and added, "the visitor who witnessed the incident did not view the incident as abusive".

The Director of Care has since submitted a Critical Incident Report, specific to staff to resident verbal abuse. [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 there is a process in place and monitored, ensuring that 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, specifically, abuse of a resident by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to resident #001 in accordance with the directions for use specified by the prescriber.

Related to Intake #027271-16, 027273-16, and 027275-16, all relating to Resident #001:

Resident #001 has a history that includes cognitive impairment.

Personal Support Workers (PSW) #054, and #055, Registered Practical Nurse (RPN) #053, Registered Nurse #051 and the Director of Care, all indicated resident #001 has known responsive behaviours, which include, inappropriate non-consensual touching of co-residents, and sexual expressions directed towards co-residents, staff and self.

The clinical health record for resident #001 details three incidents in which resident was witnessed or alleged to have inappropriately touched co-residents #002, 003 and 004, during two identified dates.

Registered Nurse #051 contacted resident #001’s attending physician on a specific date; the physician perscribed a specific anti-depressant to be given daily.

According to the eMAR (electronic medication administration record) the drug prescribed for resident #001 on an identified date was not administered until four days following the initial order date.

Registered Practical Nurse #053 indicated “the eMAR is coded “10” which means drug was not available”. RPN #053 indicated possibly that the contracted pharmacy which the home utilizes for drug orders was closed for the long weekend. RPN #053 indicated in cases where the pharmacy is closed, the registered nursing staff are to contact the on call pharmacy when drugs are required, including when there are new physician orders. RPN #053 indicated the drug for resident #001 arrived in the home on a identified date and was sent to the long-term care home, by the home's contracted pharmacy provider.

The Director of Care indicated being unaware of why the drug ordered for resident #001 was not started for four days following the order date. The Director of Care indicated that both the contracted pharmacy, as well as the on call pharmacy provider are both a round the corner.

The Director of Care indicated that noting resident #001's responsive behaviours, the medication ordered should have been initiated as per the physician's orders. [s. 131. (2)]

Issued on this 7th day of October, 2016

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

Original report signed by the inspector.