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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 30, 2021	2021_784762_0007	020567-20, 024847-20, 001533-21	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 Scarborough
3830 Lawrence Avenue East Scarborough ON M1G 1R6

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

MOSES NEELAM (762)

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): March 10-12, 15-18, and 22, 2021

The following Critical Incident Report (CIR) intakes were inspected upon during this Critical Incident System (CIS) Inspection:
Log / CIS related to an incident that lead to an injury
Log / CIS related to physical abuse
Log / CIS related to an incident that lead to an injury

During the course of the inspection, the inspector(s) spoke with Residents, the administrator, Regional Director (RD), Director of Care (DOC), Social Worker (SW), Physiotherapist (PT), Complainants, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

PLEASE NOTE:

- A Written Notification and Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s.6. (1)(c), was identified in this inspection and has been issued in Inspection Report #2021_784762_0006, dated March 30, 2021

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

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care for resident #013 is provided, specifically, the plan of care indicated that the resident's limbs are to be protected during movement

A review of the progress notes indicated that resident #013 sustained an injury during an incident which occurred when PSW #109 attempted to assist the resident. In separate interviews PSW #109 and RPN #115 indicated that the resident's the resident was not protected as required by the care plan. As a result, the resident was harmed due to the incident.

Sources: Care plan; Progress notes; Critical Incident Report ; Interviews with PSW #109 and RPN #115 [s. 6. (7)]

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 care set out in the plan of care is provided, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #011 from being physically abused by resident #012.

“Physical Abuse” is defined as:
“the use of physical force by a resident that causes physical injury to another resident”

A review of progress notes indicated that resident #012 had an incident with resident #011, which lead to an injury. In an interview, resident #011 indicated that they were not afraid of resident #012 and felt safe in the room and in the home, despite the incident, as they perceived resident #012 was not harmful. Resident #011 indicated that this was a one off incident and has not happened since. There was minimal harm to resident #011 as a result of this incident.

Sources: Progress notes; Critical incident report; Interview with resident #011 [s. 19. (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 that resident #011 is protected from physical abuse, to be implemented voluntarily.

Issued on this 12th day of April, 2021

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

Original report signed by the inspector.