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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Dec 24, 2015	2015_349590_0049	031359-15	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 SOUTHWOOD LAKES
1255 NORTH TALBOT ROAD WINDSOR ON N9G 3A4

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

ALICIA MARLATT (590)

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): November 18 & 19, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Social Workers, a Police Constable and a Community Care Access Centre (CCAC) Case Manager.

During the course of the inspection, the inspector(s) reviewed relevant policies and procedures related to inspection, one resident's clinical record, two Critical Incident System reports and the homes internal investigation notes.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
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	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. 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 that there is a written policy that promotes zero tolerance

of abuse and neglect of residents and that it is complied with.

On the first weekend in the home an incident of abuse occurred involving resident's #001 and #003; no injuries were sustained as a result of this interaction. Review of the progress notes for both resident's revealed that there was no documentation to indicate that this incident was reported to the home's Administrator, the Director of Care or their designate until the following Monday. The victim's SDM had not been made aware of the incident until the following Monday as well. The staff had initiated behaviour mapping to track the resident's behaviours and possible triggers at that time. Referrals to Behaviour Support Ontario and Social Worker's had been initiated as well. Documentation in the progress notes revealed the staff attempted to monitor this resident more closely and were able to divert resident #001 away from other resident's multiple times.

Inspector reviewed the home's policy titled "Resident Abuse By Persons Other Than Staff" policy reference # OPER-02-02-04, Version: September 2015. The policy states in the Procedures section three that:
All persons in the home are to "Immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate (e.g. supervisor, department head) must report the incident, as required by provincial legislation and jurisdictional requirements, including but not limited to: the MOHLTC Director through the Critical Incident Reporting System/after hours pager (ON). In Ontario, in addition to the above, anyone who suspects or witnesses abuse and/or neglect that causes or may cause harm to a resident is required by the LTCHA 2007 to contact the Ministry of Health and Long Term Care (Director) Action Line at 1-866-434-0144 and is protected by legislation (Whistleblower protection) from retaliation. Note: staff failure to report verbally the incident to the Administrator, Director of Care or their designate immediately could result in disciplinary action."
The policy also states in the Upon Notification section four that: The Administrator/Director of Care/Designate shall "4. a) Immediately notify the following if the resident experiences abuse that resulted in physical injury or pain or distress that can be detrimental to the health and well being of the resident: The resident's medical practitioner and request that the resident be assessed as soon as possible; The resident's SDM, if any and family; If the perpetrator is another resident, their family/POA/SDM/designate; any person required by law. And, within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse, notify the above as outlined in 4.a) of both the allegation and that an investigation has commenced."

The Critical Incident System report dates were reviewed and it indicated that the incident was first reported to the Director almost 48 hours after the incident occurred.

In an interview with the Administrator and Director of Care on November 18, 2015, they shared that they had not been made aware of the incident that occurred on the weekend, until the following Monday, during the morning meetings. When they were informed of the incident they immediately took appropriate action, informing both resident's Substitute Decision Maker's, notified the police and Director and visited with the resident's to ensure their well being. They shared that the home expects all their staff members to report these types of incidents immediately to their superiors for immediate action to occur.

On that Monday another incident occurred between resident's #001 and #002. No injuries were sustained in the interaction. The appropriate people were notified in a timely manner. However, due to the staff not reporting the initial incident which occurred on the weekend to the management staff on that same day, interventions that could have been in place to prevent the second incident from happening, were not implemented. [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 that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when discharging a resident the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. For the purposes of subsection (1), the licensee shall be informed by, in the case of a resident who is absent from the home, the resident’s physician or a registered nurse in the extended class attending the resident.

Resident #001 had begun to exhibit behaviours which had affected other resident's living in the home. The resident was transferred to the hospital for assessment. The resident was subsequently discharged from the home while absent from the home, prior to the home contacting the resident's physician or a registered nurse in the extended class attending the resident to determine if the resident was safe to return to the home.

The administrator confirmed that CCAC had been contacted and informed of the discharge the same day as the transfer to hospital.

The family member shared they did not receive the assistance they needed in planning for the resident to be admitted to another facility. The family member feared for the safety of their parent and the other residents when they agreed to the discharge and wanted to wait for a bed in a
facility with a secure unit. The family member admitted they did not realize the implications of releasing a long term care home bed without other placement arrangements made. The family member had shared that if they were made aware of the difficulty of finding another bed while in the hospital they would have never agreed to discharge the resident but would prefer the resident stay in Extendicare Southwood Lakes while waiting for a bed on a secure unit in another facility.

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 when discharging a resident the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. For the purposes of subsection (1), the licensee shall be informed by, (a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or (b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident, to be implemented voluntarily.

Issued on this 24th day of December, 2015

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

Original report signed by the inspector.