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
Feb 28, 2020	2020_678590_0002	000752-20	Complaint

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 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 Complaint inspection.

This inspection was conducted on the following date(s): February 3 - 7, 2020.

LSAO Log #023863-19 with associated CIS #2842-000066-19 was related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care, one Clinical Care Coordinator, one Social Worker, two Registered Practical Nurses, two Personal Support Workers, one security guard, two residents and one family member.

During the course of the inspection, the inspector(s) observed resident/resident interactions, staff/resident interactions, infection prevention and control practices, the posting of required information and the general cleanliness and maintenance of the home.

During the course of the inspection, the inspector(s) reviewed two residents' clinical records, Risk Management reports, Paladin Security Daily Report Sheets and an Incident Report, Critical Incident System reports and written policies and procedures related to inspection topics.

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.
- **2 WN(s)**
- **1 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. 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 has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

For the purpose of this inspection, The Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10 defined physical abuse as “the use of physical force by a resident that causes physical injury to another resident”.

A complaint was received by the Ministry of Long-Term Care (MOLTC) reporting concerns about the safety of resident #003 and the behaviours of resident #004. The complainant reported that resident #003 had been attacked by resident #004 and that resident #003 sustained an injury which required medical treatment. The complainant reported that they knew that resident #004 was supposed to have a specific intervention in place while at the home. The complainant reported that this altercation took place in the evening on an identified date.

Review of resident #003’s progress notes for the identified date showed documentation about an altercation that took place between resident #003 and 004. The note described that resident #003 was initially observed by a Personal Support Worker (PSW) to be standing outside their bedroom door agitated, yelling and with minor injuries visible. Resident #004 was observed to exit the room and hit resident #003 and that was when staff reached the residents to intervene and separated them. Resident #003 stated to staff, who documented the comment, that they were physically assaulted in their room. Further review of the clinical record showed that resident #003 sustained an injury from the altercation that required medical intervention.

Review of resident #004’s clinical records showed that this resident was cognitively impaired. The progress notes written on the identified date were reviewed. The note documented that a PSW had reported to registered staff that resident #004 entered the room of resident #003. The writer of the note and the reporting PSW responded immediately and approached the room. They found resident #003 standing in the hallway just outside the room, and resident #004 exiting the room pursed to swing with closed fists towards resident #003. Resident #003 was struck and staff intervened. The staff were able to isolate resident #004 in a safe space until they were able to calm down. Resident #004’s care plan that was in place at the time of the incident was reviewed. The care plan identified a focus on behaviours and listed many interventions for behaviour management that the staff could utilize when needed and one intervention that was to always be in place.

There was an Incident Report completed for this incident and it was reviewed. The staff

documented that at 2001 hours they could not locate resident #004 so they informed the nursing staff. At 2005 hours they could still not locate resident #004. At 2010 hours resident #003 exited their room and appeared to be injured. The staff asked resident #003 if they were alright and the resident responded that they had hit them, referring to resident #004. The staff left the area to inform the nursing staff then returned to try and get resident #004 to leave resident #003's room. At 2013 hours as resident #004 exited resident #003's room, resident #004 lunged at resident #003. The staff wrote that nursing staff got in between them and took resident #003 from the area.

In an interview with Registered Practical Nurse (RPN) #103, they shared that they were working the evening of the altercation. They said that a specific intervention was supposed to be in place for resident #004 all the time, and that the intervention had not been in place at the time of this incident.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", policy number RC-02-01-01 and last updated in June 2019, provided an explanation that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. The policy defined physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

In an interview with Director of Care (DOC) #100 they acknowledged that resident #003 was injured as a result of resident #004's actions, and also acknowledged the homes' responsibility to keep them safe. They shared that follow up has been done will all persons involved in resident #004's care. [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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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 that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by the MOLTC reporting concerns about the safety of resident #003 and the behaviours of resident #004. The complainant reported that resident #003 had been attacked by resident #004. The complainant reported that they knew that resident #004 was supposed to have a specific intervention in place while at the home. The complainant reported that this altercation took place in the evening on an identified date.

Review of resident #004’s clinical records showed that this resident was cognitively impaired. Resident #004’s care plan that was in place on the date of the incident, was reviewed. The care plan identified a focus on behaviours and listed many interventions for behaviour management that the staff could utilize when needed and one intervention that was to always be in place.

There was an Incident Report completed for this incident and it was reviewed. The staff documented that at 2001 hours they could not locate resident #004 so they informed the nursing staff. At 2005 hours they could still not locate resident #004. At 2010 hours resident #003 exited their room and appeared to be injured. The staff asked resident #003 if they were alright and the resident responded that they had hit them, referring to resident #004. The staff left the area to inform the nursing staff then returned to try and get resident #004 to leave resident #003’s room. At 2013 hours as resident #004 exited Resident #003’s room, resident #004 lunged at resident #003. The staff wrote that nursing staff got in between them and took resident #003 from the area.

In an interview with RPN #103, they shared that they were working the evening of the altercation. They said that a specific intervention was supposed to be in place for resident #004 all the time, and that the intervention had not been in place at the time of this incident.

In an interview with DOC #100 they stated that resident #004's plan of care had not been followed. They shared that follow up has been done will all persons involved in resident #004's care. [s. 6. (7)]

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.