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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 25, 2014	2014_256517_0010	L-000142-14	Complaint

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

PATRICIA VENTURA (517)

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 25 & 26, 2014

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

During the course of the inspection, the inspector(s) reviewed three resident health records, reviewed the home's policies and procedures for abuse and neglect, responsive behaviours and reviewed the staff's training records for abuse and neglect.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 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 report to the Director when there were reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to a resident as evidenced by:

- One resident was the recipient of verbal abuse by another resident causing distress that could be detrimental to the health and well being of the recipient.

- The home's policy Resident Abuse By Persons Other Than Staff policy # OPER-02-02-04 defines verbal abuse as any form of verbal communication that includes, but is not limited to screaming, intentionally confusing or degrading a resident, threatening or intimidating.

- The policy states the home must report any suspected or witnessed abuse to the MOHLTC Director through the Critical Incident Reporting System and must immediately notify any person or body required by law 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.

Management staff confirmed these incidents were not reported to the Director. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence as evidenced by:

Two residents sustained injuries as a result of resident to resident physical abuse.

The home treated the incidents as physical abuse and completed Critical Incident reports for the incidents. The police was not notified of the incidents of physical abuse.

Management staff confirmed that the police had not been notified of this incident of physical abuse. [s. 98.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention annually as evidenced by:

- The sign in sheets and records for staff training on Abuse and Neglect showed not all nursing department staff received the training.

- Management staff confirmed not all direct care staff at the home received annual mandatory training on abuse recognition and prevention. [s. 221. (2)]

Issued on this 25th day of March, 2014

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

PATRICIA VENTURA