Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimilie: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Quest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
October 15, 2010	2010_192_2321_15Oct092458	Critical Incident (H – 01202)

Licensee/Titulaire
Extendicare Southwestern Ontario Inc.
(a subsidiary of Extendicare (Canada) Inc.)
3000 Steeles Avenue East
Suite 700
Markham, ON, L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée
Extendicare St. Catharines
283 Pelham Road
St. Catherines, ON, L2S 1X7

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

Barbara Naykalyk-Hunt # 146, Debora Saville #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection related to a Critical Incident Report.

During the course of the inspection, the inspectors spoke with: The Administrator, Director of Care, and the resident

During the course of the inspection, the inspectors: Reviewed the homes investigation notes, the residents medical record, the homes Abuse Policy and training records on the abuse policy.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCH Act, 2007, S.O. 2007, c. 8, 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.

Findings:

1. Abuse and Aggression Policy document # 02-06-01 dated January 2004 indicates: "In all cases where sufficient evidence exits to substantiate and allegation of physical or sexual abuse, the administrator or delegate must notify the police."

2. During interview, it was confirmed by the Administrator that the police were not called related to an identified critical incident involving allegations of abuse.

Inspector ID #:	#146, #192

WN #2: The Licensee has failed to comply with **LTCH Act, 2007, S.O. 2007, c. 8, 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.

Findings:

1. Documentation in the progress notes indicates that a resident told staff about being mishandled, including a description of the person responsible for causing the abuse.

2. An interview with the Administrator and Director of Care, and documentation in the employee's record confirmed that the incident occurred.

Inspector ID #:	#146, #192

WN #3: The Licensee has failed to comply with **LTCH Act, 2007, S.O. 2007, c. 8, 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,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. A Resident Assessment Protocol (RAP) identifies a deficit as a concern for a resident; the care plan was not updated to provide clear direction to staff and others who provide care.

2. The progress notes identify on multiple occasions that a resident demonstrated frequent behaviours. The care plan does not set out clear direction to staff and others on the management of these responsive behaviours.

Inspector ID #:	#146 #192

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Deborah Saville
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Dec 22/2010