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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Oct 4, 2019	2019_820130_0005	000871-18, 003181-19, 009253-19, 017849-19	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 St. Catharines
283 Pelham Road St. Catharines ON L2S 1X7

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

GILLIAN HUNTER (130), AILEEN GRABA (682), KELLY CHUCKRY (611)

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): September 18, 19, 20, 23, 24, 25, 26, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed the provision of care, reviewed relevant resident clinical records, relevant policies and procedures, investigation notes and critical incident reports.

This inspection was conducted related to the following intakes:
- Log # 000871-18 related to falls management and prevention
- Log # 003181-19 related to falls management and prevention
- Log # 009253-19 related to prevention of abuse and neglect
- Log # 017849-19 related to significant change in condition.

PLEASE NOTE: This Critical Incident (CI) inspection was conducted concurrently with a Complaint inspection #2019_820130_0004 and a Follow Up inspection #2019_820130_0003.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Dietary Manager, Quality Improvement and Clinical Care Coordinator, registered staff, Personal Support Workers (PSW)s, residents and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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 :

The licensee has failed to ensure that resident #009 was protected from abuse by staff #111.

The plan of care for resident #009 indicated they had a specific diagnosis and were independent with a specific activity of daily living (ADL).

Critical incident 2891-000011-19 submitted in 2019, described an incident where on an identified date in May 2019, resident #009 had taken an item belonging to PSW staff #111. The incident led to Staff #111 taking a specific action with resident #109, despite the resident's resistance, which resulted in a fall with injury to the resident.

In an interview, RPN #106, who was present during the incident, confirmed that after the resident fell, PSW staff #111 said they were taking the resident to the room for a specific purpose. Staff #106 confirmed that staff #111's action was not appropriate given the resident's diagnosis.

A written statement from RN #119 and a review of progress notes, confirmed that staff #111's action with resident #009 was witnessed and resulted in the resident's fall with injury. RN #119 documented that the resident appeared visibly upset over the altercation.

The Administrator confirmed in an interview that staff #111 received a discipline as a result of the incident and that resident #009 was not protected from abuse by staff #111.

Please note: This evidence further supports compliance order (CO) #002, that was issued on May 14, 2019 related to the same section, of the LTCHA 2007, s. 19 (1), with a compliance due date of August 9, 2019.

This non-compliance occurred prior to the compliance due date.

Issued on this 4th day of October, 2019

[redacted]

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

Original report signed by the inspector.