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
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
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2013	2013_205129_0009	H-000419-13	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO 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. Catharines, ON, L2S-1X7

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

---

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 30 and 31, 2013

This Critical Incident inspection (Log # H-000419-13) related to resident abuse was conducted following receipt of a Critical Incident Report submitted by the home.

During the course of the inspection, the inspector(s) spoke with the resident, a resident family member, registered and unregulated nursing staff, the staff person responsible for monitoring mandatory education, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed clinical records,reviewed staff personnel records,reviewed the home's records documenting the completion of mandatory education related to Prevention of abuse and reviewed the home's policy [Resident Abuse - Staff to Resident]

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure resident #005's right to be protected from abuse was fully respected and promoted, in relation to the following: [3(1)2]
On an identified date resident #005 was being assisted to the washroom by a personal support worker who pushed the resident in an attempt to have the resident hurry. This action caused the resident to loose balance and fall into the wall, resulting in the resident receiving an injury. Registered staff #101, #106 and clinical documentation indicated that the resident was very upset about the incident and explained that the staff person was trying to make the resident hurry but the resident's legs would not work right and that the resident felt this was physical abuse. Clinical documentation confirmed that the resident has a medical condition that affects mobility and at the time of this inspection the resident was noted to use an aid to assist with ambulation and the residents movements were very slow and unsteady. [s. 3. (1) 2.]

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 and ensuring that the right of all residents to be protected from abuse is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. Staff who had reasonable grounds to suspect that abuse of resident #005 had occurred did not immediately report this information to the Director, with respect to the following: [24(1)2

Three registered staff working in the home who became aware of a situation of suspected staff to resident abuse did not immediately report this abuse to the Director. Resident #005 reported to staff in the home on June 29, 2013 that a personal support worker had pushed the resident in an attempt to hurry the resident during care, which resulted in the resident losing balance and falling into the wall. Clinical documentation made by staff indicated that the resident felt this was physical abused and staff documented that they noted the injury the resident sustained following this incident. With the support of the resident's sister the resident reported the incident to registered staff #101 two days following the incident. This staff member and clinical documentation confirmed that a second registered staff #105 was contacted by phone and provided the details of the incident; however staff #101 did not immediately report this incident of abuse to the Director. On the same day registered staff #106 and clinical documentation confirmed that the resident asked to speak with this staff and described the incident in detail, following which this staff member contacted registered staff #105 who indicated she was aware of the situation; however registered staff #106 did not immediately report this information to the Director. Registered staff #105 submitted a critical incident, identifying abuse to the Hamilton Area Service Office seven days after she and two other staff became aware of this report of staff to resident abuse. [s. 24. (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 and ensuring that staff who have reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee did not ensure that all staff at the home received training related to the home's policy to promote zero tolerance of abuse and neglect of residents on an annual basis in accordance with O. Reg. 76/10, s. 219(1), with respect to the following: [76(2)3]

Training records provided by the home for 2012 confirmed that 71 of 178 staff employed by the home did not receive training in relation to the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (2) 3.]

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 and ensuring that all staff receive annual retraining related to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #4: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with, in relation to the following: [20(1)] Staff in the home did not comply with the home's policy [Resident Abuse-Staff to Resident] identified as #OPER-02-02-04 and dated March 2013 which directs that the Administrator, Director of Care or their designate must report incidents of abuse of residents as required by provincial legislation. The Director of Care became aware of a situation of resident abuse on an identified date when this staff person received a phone call from registered staff #101 and a second phone call from registered staff #106 describing the incident. The Director of Care did not report this incident of suspected abuse to the Director for seven days when a Critical Incident Report was submitted to the Hamilton Service Area Office. [s. 20. (1)]

2. The licensee did not ensure that the homes policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports, in regards to the following: [20(2) (d)]
The home's policy [Resident Abuse – Staff to Resident] identified as #OPER-02-02-04, dated March 2013 does not contain an explanation that [a person] shall immediately report a suspicion of resident abuse in accordance with section 24 of the Act. The home's policy identifies three people [the Administrator, Director of Care or their designate] as the people who must report incidents of abuse. [s. 20. (2)]

Issued on this 22nd day of August, 2013

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