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 le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 13, 2012	2012_034117_0008	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE STARWOOD
114 STARWOOD ROAD, NEPEAN, ON, K2G-3N5

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), an attending physician, to the Support Services Manager, to several unit Registered Nurses (RN), to several unit Registered Practical Nurses (RPN), to several Personal Support Workers (PSW), to a resident family member and to three identified residents.

During the course of the inspection, the inspector(s) reviewed the health care records of three identified residents; reviewed the home's policy on Resident Abuse # RESI-02-06-01, revised September 2011; reviewed the home's education training calendar for October 2011; examined a resident bed and side rails; and reviewed three Critical Incident Reports.

It is noted that three Critical Incident Inspections were conducted during the course of this inspection: log #O-000270-12, #O-000210-12 and #O-002858-11

PLEASE NOTE THAT THIS INSPECTION WAS CONDUCTED ON FEBRUARY 6, 7, 8, 9 AND 13, 2012.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007 Section 23 (1) (a) (i) in that on an identified day in January 2012, an RN and an RPN failed to ensure that any allegations of abuse reported by an identified resident be immediately investigated. [O-000270-12]

On an identified day in January 2012, an identified resident told several PSWs on the day shift, that he/she had been abused during the night.

The PSWs reported the incident to the unit RPN. The RPN notified the unit RN of the resident's statements related to being a victim of abuse during the night.

The RN and RPN stated during interviews on February 6, 2012, that they did not assess the resident after they had been notified of the resident's statements of having been abused during the night.

The RPN and the RN did document in the resident's health care record and unit 24-hour nursing report that the resident was repeatedly stating that he/she had been abused during the past night. There is no documentation of any assessment and investigation being done.

On another specified day in January 2012, the identified resident stated to the another RPN that he/she had been abused during the night. The RPN immediately reported the incident to the home's management. The home immediately initiated an investigation, notified the resident's family, notified local police and notified the Director. Investigation later found no evidence that the incidents of abuse occurred.

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 in regards to ensuring that every alleged, suspected or witnessed incident of the abuse of a resident by anyone that is reported to the licensee, be immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Under the LTCHA 2007 section 20 (1) the licensee is to have a policy to promote zero tolerance. The licensee's policy Resident Abuse # RESI-02-06-01, revised September 2011, states the following under the titles:

- Reporting an Allegation : "All employees and volunteers: Immediately report any suspected or witnessed acts of abuse to: the Administrator, Director of Care or their designate".

- Accountabilities for Compliance: "All employees - Required to report any incidents of alleged, suspected or witnessed act of abuse immediately to the Administrator, Director of Care or designate."

On an identified day in January 2012, an identified resident told several PSWs on the day shift, that she had been abused during the night.

The PSWs reported the incident to the unit RPN. The RPN notified the unit RN of the resident's statements related to being abused during the night.

The RN and RPN stated during interviews on February 6, 2012, that they did not assess the resident after they had been notified of the resident's statements of having being abused during the night.

The RPN and the RN did document in the resident's health care record and unit 24-hour nursing report that the resident was repeatedly stating that she had been abused during the past night. There is no documentation of any assessment and investigation being done.

The RN also failed to report to the home's Administrator, Director of Care or designate, the resident's statements of having been abused as per the home's abuse policy :Resident Abuse # RESI-02-06-01.

On another specified day in January 2012, the resident stated to the another RPN that she had been abused during the night. The RPN immediately reported the incident to the home's management. The home immediately initiated an investigation, notified the resident's family, notified local police and notified the Director. The investigation later found no evidence that an incidents of abuse occurred.

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 in regards to ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone is reported to the licensee and is immediately investigated, as per the Licensee's Abuse Policy,, to be implemented voluntarily.

Issued on this 13th day of February, 2012

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

Lynn Duchesne #117