Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 13, 2019	2019_786744_0032	017395-19, 018684-19, 018943-19	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 Timmins
62 St-Jean Avenue TIMMINS ON P4R 0A6

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

STEVEN NACCARATO (744)

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): October 28-31, 2019.

The following intakes were inspected during the Critical Incident Systems (CIS) inspection:
-One intake related to a critical incident that the home submitted to the Director regarding an incident resulting in an injury;
-One intake related to a critical incident that the home submitted to the Director regarding alleged staff to resident abuse;
-One intake related to a critical incident that the home submitted to the Director regarding missing medication.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physician, Physiotherapist, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted a tour of the resident care areas, reviewed residents' health
care records, home policies and procedures, investigation notes, mandatory training records,
staff schedules and personnel records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone had occurred, or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #002 was alleged to have been abused by Personal Support Worker (PSW) #108. The CI report further indicated that resident #002 became very upset and was fearful of PSW #108.

A) The licensee's policy titled "Zero Tolerance of Resident Abuse and neglect Program" indicated that "Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse or neglect at all times. Extendicare has a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated. Prevention of abuse and neglect is fundamental to the zero-tolerance program".

In an interview with Inspector #744, resident #002 stated that on specified date, PSW #108 was abusive to them.

Inspector #744 interviewed PSW #111, who stated that they witnessed PSW #108 being abusive to resident #002.

In an interview with Inspector #744, PSW #109 stated that when they provided care for resident #002 the morning after the incident, the resident stated that they did not want PSW #108 in their room anymore because they were afraid of them.

B) The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", indicated that "Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to most senior Supervisor on shift at that time".

In an interview with Inspector #744, PSW #111 stated that allegations of abuse were to be reported immediately to registered staff. PSW #111 further stated that as soon as they observed resident #002 being abused they immediately notified RPN #110 who stated

that they were already aware of the situation.

Inspector #744 interviewed RPN #110 who stated that they charted in the resident's electronic progress notes that PSW #111 had witnessed resident #002 being upset. RPN #110 further stated that they did not report this incident to management because they believed that PSW #111 resolved the situation and that the resident did not express any concerns to them, until three or four days after the incident had occurred.

In an interview with Inspector #744, the Director of Care (DOC) stated that they interviewed resident #002 about the incident and it was clear that the resident was upset. The DOC further stated that there was no doubt that abuse had occurred based on the matching stories from the resident and staff. The DOC also stated that RPN #110 should have investigated and reported the incident of abuse immediately. [s. 20. (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 to 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, 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. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred immediately reported the suspicion and the information upon which it was based to the Director: 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.

A Memorandum titled "Clarification of Mandatory and Critical Incident Reporting Requirements", dated July 05, 2018, was sent to all Long-Term Care Home Licensees. This memorandum identified that "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: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident".

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #002 was alleged to have been abused by Personal Support Worker (PSW) #108. Please see WN #1 for details.

Inspector #744 reviewed the CI report which indicated that the DOC was made aware by PSW #109, of an alleged abuse on a specified date; however, the CI was submitted to the Ministry of Health a day later.

The licensee's policy titled "Mandatory and Critical Incident Reporting (ON)", indicated that "Mandatory reporting under the LTCHA (Ontario): Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a responsible suspicion that certain incidents occurred or may occur." Included in the list of mandatory reporting incidents as mentioned in the policy is 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.

In an interview with Inspector #744, the DOC indicated that they were aware that the allegation of abuse should have been reported immediately but could not submit the intake on time because they were occupied with completing other critical incidents the home received. [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 to ensure 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of a change in a resident's condition that resulted from an incident in which the resident was taken to the hospital.

A Memorandum titled "Clarification of Mandatory and Critical Incident Reporting Requirements", dated July 05, 2018, was sent to all Long-Term Care Home Licensees. This memorandum identified that "The following critical incidents in the home must be reported to the Director within one business day after occurrence of the incident, followed by the written report referred to in subsection 107(4): an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition".

The home submitted a Critical Incident (CI) report to the Director on a specified date, which indicated that resident #001 had an incident that resulted in an injury a few business days prior.

The licensee's policy titled "Mandatory and Critical Incident Reporting (ON)", indicated that the Director was to be informed no later than one business day after an accident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital.

In an interview with Inspector #744, the DOC indicated that they reported this incident late because they were occupied with completing other critical incidents the home received. [s. 107. (3) 4.]

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.