Ontario

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
May 22, 2020	2020_746692_0007	003103-20	Complaint

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 Tri-Town
143 Bruce Street P.O. Box 999 HAILEYBURY ON P0J 1K0

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 2-6, 2020.

The Following intake was inspected upon during this Complaint Inspection:
-One log, which was related to a complaint that was submitted to the Director related to staffing concerns, an allegation of staff to resident abuse and missing medications.

A Follow Up Inspection #2020_746692_0006 was conducted concurrently with this inspection.

Please note: A compliance order related to s. 8 (3) was identified in this inspection and has been issued in Follow Up inspection report #2020_746692_0006, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Office Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, the home’s complaint log, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
3 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 the home's written policy to promote zero tolerance of abuse was complied with.

Verbal abuse is defined within the Ontario Regulation (O.Reg) 79/10 of the Long Term Care Homes Act (LTCHA) as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident". Furthermore, emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

A complaint was submitted to the Director on an identified date, regarding resident care concerns, including that there had been an incident involving staff to resident verbal and emotional abuse towards a resident, and that the Substitute Decision Maker (SDM) had not been notified.

In an interview with the Administrator/Director of Care (DOC), they indicated to Inspector #692 that there had been an incident that had occurred on an identified date, whereby Personal Support Worker (PSW) #110 was verbally abusive towards resident #004, causing them to become distressed and upset.

Inspector #692 reviewed the home's internal investigation notes, which included interviews that the home's management had conducted with the staff members involved with the incident. The investigation notes identified that on the identified date, PSW #101 and Registered Practical Nurse (RPN) #102 had reported to the Administrator/DOC that

they both had observed PSW #110 being verbally abusive towards resident #004, causing them to become upset after the incident occurred.

A review of the home’s policy titled, “Extendicare Zero Tolerance of Resident Abuse and Neglect Program, #RC-02-01-01”, last updated June 2019, indicated that Extendicare had a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. A further review of the policy indicated that the policy applies to all staff members.

In separate interviews with PSW #101 and RPN #102, they both indicated to Inspector #692 that they had witnessed PSW #110 being verbally abusive towards resident #004, describing what they had witnessed. RPN #102 indicated that they felt that PSW #110 had belittled the resident in the way that they had spoken to them, and felt it was abusive. Both PSW #101 and RPN #102 identified that they had reported what they witnessed to the Administrator/DOC immediately after the incident had occurred.

Inspector #692 interviewed the Administrator/DOC, who indicated that the incident, whereby PSW #110 had been verbally abusive towards resident #004 had been founded. They indicated that the home’s abuse policy identified that the home had a zero tolerance for resident abuse, and that PSW #110 had not followed the policy when they were abusive towards resident #004. [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 the home's written policy to promote zero tolerance of abuse 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint had been submitted to the Director on an identified date, regarding resident care concerns, including that there had been an incident involving staff to resident verbal and emotional abuse towards a resident, and that the SDM had not been notified.

Please see Written Notice (WN) #1, for further details.

Inspector #692 reviewed the Ministry of Health and Long-Term Care's online critical incident reporting portal and noted that a Critical Incident System (CIS) report had not been submitted to the Director regarding the above mentioned allegation of staff to resident abuse.

In a review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, #RC-02-01-02", last updated June 2019, it identified that management was to promptly and objectively report all incidents to external regulatory authorities. Inspector #692 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, #RC-02-01-03", last updated June

2019, which indicated that the Administrator or designate was to ensure that reporting requirements to provincial/regulatory bodies had been completed as required.

In an interview with Registered Nurse (RN) #104, they indicated that if there had been a witnessed or an alleged incident of resident abuse, from anyone, the home was to report it to the MLTC immediately.

On November 2, 2018, the Director informed Licensees of a Tip Sheet with Simplified Reporting Requirements and was based on the August 31, 2018, memo "Clarification of Mandatory and Critical Incident Reporting Requirements".

In an interview with the Administrator/DOC, they indicated that all allegations of resident abuse were to be immediately reported to the Director of Long-Term Care by the home. Together, the Administrator/DOC and the Inspector reviewed the Tip Sheet identifying under mandatory reporting, that abuse of a resident that resulted in harm was to be reported to the Director immediately. The Administrator/DOC indicated that they had not thought of reporting the incident of staff to resident abuse; however, they identified that they should have reported the incident to the Director immediately. [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 that the person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was notified immediately upon the licensee becoming aware of a witnessed incident of abuse of the resident that resulted in distress to the resident that could potentially be detrimental to the resident's health or well-being.

A complaint was submitted to the Director on an identified date, regarding resident care concerns, including that there had been an incident involving staff to resident verbal and emotional abuse towards a resident, and that the SDM had not been notified.

Please see WN #1, for further details.

Inspector #692 reviewed the homes policy titled, "Extendicare Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02", last updated June 2019, which identified that disclosure of the alleged abuse would be made to the resident's SDM immediately upon becoming aware of the incident.

In separate interviews with PSW #101 and RPN #102, they both described to Inspector #692 what they had witnessed involving PSW #110 towards resident #004 on an identified date. RPN #102 indicated that they had not notified resident #004's SDM after the incident had occurred, as they thought the Administrator/DOC had completed that.

During an interview with the Administrator/DOC, they indicated to the Inspector that the SDM was to be notified immediately when there had been an incident of resident abuse, resulting in harm to the resident. The Administrator/DOC identified that they had not notified resident #004's SDM when the incident had been reported to them, and they should have. [s. 97. (1) (a)]

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 the resident’s Substitute Decision Maker (SDM) is notified immediately upon the licensee becoming aware of a witnessed incident of abuse of the resident that results in distress to the resident that could potentially be detrimental to the resident’s health or well-being, to be implemented voluntarily.

Issued on this 29th day of May, 2020

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

Original report signed by the inspector.