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

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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
May 2, 2019	2019_617148_0009	028736-18, 030385-18, 000578-19, 001213-19, 001799-19	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 West End Villa
2179 Elmira Drive OTTAWA ON K2C 3S1

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

AMANDA NIXON (148), EMILY BROOKS (732)

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): March 26-29 and April 1-3, 2019

This inspection included five critical incident reports (CIR): Log 030385-18 (CIR #2709-00026-18) and 000578-19 (CIR #2709-000001-19), related to an incident that causes injury for which the resident is taken to hospital and results in significant health change; Log 001799-19 (CIR #2709-000005-19), Log 028736-18 (CIR #2709-000024-19) and Log 001213-19 (CIR #2709-000004-19), related to related to staff to resident alleged neglect and/or abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator (CC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Office Manager, Scheduler, Resident Advocate and residents.

In addition the Inspector(s) reviewed resident health care records, relevant policies and documents related incidents of alleged abuse and neglect. The Inspectors also observed the resident care environment, resident care and staff to resident interaction.

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

During the course of this inspection, Non-Compliances were issued.
- **7 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

A Critical Incident Report was submitted to the Director describing emotional abuse and neglect by PSW #124 towards resident #005 over several days. Upon investigation, the licensee determined that PSW #124:
-failed to provide morning care to the resident on a specific date;
-failed to provide assistance with activities of daily living (ADL);
-failed to respond verbally and did not check on the resident; and
-ignored a request from the resident.

In an interview, DOC #101 told Inspector #732 that the 'Task Care Record' PSW staff use to document the care they provide to a resident, lays out the resident's needs for ADL's and is included in the resident plan of care. Inspector #732 reviewed resident #005's task care record for a specified time period. The task care record indicated that resident #005 was independent with dressing and independent with hygiene.

In an interview with resident #005, they stated that they suffer from a certain disease and have required some level of assistance with dressing and hygiene since admission to the home.

Inspector #732 reviewed resident #005's Minimum Data Set (MDS) assessment of a specific date. This assessment indicated that resident #005 required extensive assistance with dressing and limited assistance with personal hygiene. During interviews, RN #120, RPN #117, CC #102, and DOC #101 all confirmed that resident #005 required some level of assistance with dressing and personal hygiene at the time of the incident. Upon review of resident #005's task care record for a specific month, both CC #102 and DOC #101, reported that the resident's plan of care was not reflective of the resident's need for assistance with dressing and hygiene.

Therefore, the licensee has failed to ensure that resident #005's plan of care was based on an assessment of the resident's needs and preferences.
(log #001799-19)

2. The licensee has failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

The plan of care for resident #004 describes the resident as requiring extensive assist for dressing, bed mobility and personal hygiene. During continence care, staff are to assist with peri care and with the adjustment of clothing.

As described by WN #2, related to section 23 of the LTHCA, 2007, a critical incident report was submitted to the Director describing the alleged abuse and neglect of resident #004.

With respect to the critical incident report submitted, Inspector #148 reviewed the video footage for specified dates.

The Inspector observed the continence care provided by either PSW #114 or PSW #115 within the identified videos. On seven occasions, a staff member was observed to not assist the resident with the readjustment of the product, undergarments and/or pants. The staff member would leave the resident alone after the product was changed and the resident repositioned self, sometimes to standing, and readjusted clothing.

(Log 001213-19)

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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:

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; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(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 :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone and neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and that appropriate action is taken in response to every such incident.

In accordance with section 2 of O. Regulation 79/10, emotional abuse means 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. Neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified day, the DOC had a discussion with resident #004 and the resident's substitute decision maker (SDM). As indicated by the DOC's documentation and as reported during an interview with the Inspector, concerns were brought forward indicating that during the provision of continence care at during the night shift, resident #004 was not provided with dressing assistance. In addition the concerns discussed included the attitude of staff on night, with specific mention of PSW #114, who was described as arguing and blaming resident #004. The DOC reported that the care provided by both night PSW #114 and PSW #115 were discussed during this meeting.
Two days later, the DOC sent an email message to the regular night shift charge RN

#112. The email asked RN #112 to monitor PSW #114 and PSW #115. The email indicted that concerns had been brought forth related to resident #004, that the identified night staff were not providing continence and dressing care as required and that the resident finds this degrading. The Inspector reviewed the schedule and spoke with RN #112, whereby it was confirmed that RN #112 did not work in the home during the specified period of time. The Inspector spoke with the RNs who worked on night shift during the specified period of time; RN #121, RN #122, RN #123, were not aware of the request to monitor the identified PSWs and indicated that no monitoring had occurred. The schedule during the specified period of time, indicated that PSW #114 worked three shifts on resident #004's and PSW #115 worked two shifts on resident #004's unit.

Four days after the initial discussion with the resident and SDM, evening RN #111, took a complaint from the SDM of resident #004 and documented the concerns on the West End Villa Concern Form; on the same shift, RN #111 made a call to the DOC and reported the concerns. The Concern Form described concerns with continence care and the way in which PSW #114 and #115 speak to resident #004, including name calling.

In an interview with the DOC, it was reported that the concerns noted on the Concern Form were already known to the DOC from the initial discussion with the resident and SDM. The Concern Form's Action Plan, completed by the DOC on the following day, indicated that the same concerns were expressed during a meeting with the resident and SDM, four days earlier.

The DOC reported information related to both complaints, to the Administrator's five days after the initial discussion with the resident and SDM, at which time an investigation was initiated whereby the DOC interviewed eight residents who resided on the same unit as resident #004, regarding their experiences with night care. On the same day, the DOC met with the SDM of resident #004, whereby the SDM stated that video footage was available for the DOC to review; PSW #114 and #115 were placed on leave pending the investigation.

The video evidence was received and reviewed by the DOC and Administrator two days later. On the same day, mandatory reports were made to the local police force and to the Director (Ministry of Health and Long-Term Care). As indicated by the CIR sent to the Director, the licensee investigation had determined that there was evidence of abuse and neglect.

The licensee failed to ensure a suspected incident of resident abuse and neglect, that

was reported to the licensee, was immediately investigated and that appropriate action was taken. The two identified PSWs continued to provide care to the resident during the specified period of time.

Additional non-compliance related to this CIR, has been identified under s.6, s.20(1), s.24 (1) 2 and s.76(4) of the LTCHA, 2007; see WN #1, WN #5, #6 and WN #7.

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone and neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and that appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #3: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

Every licensee of a long-term care home shall ensure that the right to be afforded privacy in treatment and in caring for his or personal needs are fully respected and promoted:

As described by WN #2, related to section 23 of the LTHCA, 2007, a critical incident report was submitted to the Director describing the alleged abuse and neglect of resident #004.

With respect to the critical incident report submitted, Inspector #148 reviewed the video footage, as available. In review of video evidence related to the alleged abuse and neglect of resident #004, PSW #116 was observed to assist resident #004 with the changing of an incontinence product on a specified date. The resident stood at the transfer pole at bedside while care was provided. At the time of the provision of care, the privacy curtains were open as well as the bedroom door; passersby in the hallway can be seen.

In this way, resident #004 was not provided with privacy in personal care needs.

(Log 001213-19)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

On March 26, 2019, resident #001 was observed to be wheeled to the resident's room by a PSW staff member. Inspector #148 spoke with resident #001 in the resident's room to discuss care and services in the home. During the interaction the Inspector asked how the resident would call staff to the room to which the resident identified the use of the call bell. The Inspector observed that the call bell cord, extending from the wall opposite to where the resident was seated, was draped between the head board and mattress, leaving the cord end with call button near the floor between the bed frame and side table. The resident was seated in a wheelchair and was unable to propel the chair further to reach the call bell.

In this way the communication and response system was not easily seen or accessed for use by the resident.

(Log 028736-18)

WN #5: 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 :

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect is complied with.

A policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, #RC 02-01-02, was identified as part of the home's policy to promote zero tolerance of abuse and neglect of residents. The policy indicated that the Administrator or Designate will immediately initiate an investigation of the alleged, suspected or witnessed abuse and that all staff will immediately respond to any form of alleged, potential, suspected or witnessed abuse and neglect.

As described by WN #2, related to section 23 of the LTHCA, 2007, a critical incident report was submitted to the Director, describing the alleged abuse and neglect of resident #004. Reasonable grounds to suspect resident abuse and neglect were known to the DOC on a specified date related to resident #004. The DOC reported that actions were taken two days later when an RN was directed to monitor the two identified PSWs. The DOC and Administrator discussed the complaints received and pending video five days later, whereby an investigation was initiated.

In this way the policy to promote zero tolerance of abuse and neglect of residents was not complied with describing the alleged abuse and neglect of resident #004

(Log 001213-19)

WN #6: 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 :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that 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, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

As described by WN #2, related to section 23 of the LTHCA, 2007, reasonable grounds to suspect resident abuse and neglect were known to the home's DOC on two identified dates, related to resident #004. The DOC and Administrator discussed the complaints received and pending video five days after the initial information was received, whereby an investigation was initiated and the two identified PSW staff members were place on leave pending the investigation.

The licensee submitted a report to the Director two days after an investigation was initiated and seven days after the initial information was received, describing the incidents of alleged resident abuse and neglect of resident #004. In this way, the report to the Director was not immediate.

(Log 001213-19)

WN #7: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

The licensee failed to ensure that that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

In accordance with section 76 (1) and (2) of the LTCHA and section 219 (1) of O. Regulation 79/10, all staff are to receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and that such staff will be provided such training at annual intervals.

As described by WN #2, related to section 23 of the LTHCA, 2007, a critical incident report was submitted to the Director describing the alleged resident abuse and neglect of resident #004.

In review of the training provided to staff involved in the alleged incident of abuse and neglect, it was determined that RN #111 had last been provided with training on the home's policy to promote zero tolerance of abuse and neglect in August 2017. In this way, RN #111 was not provided with training at annual intervals as required.

(Log 001213-19)

Issued on this 21st day of May, 2019

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

Original report signed by the inspector.