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
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AMENDED - Feb 23, 2016

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2016	2016_282543_0002	000533-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

TIFFANY BOUCHER (543), SARAH CHARETTE (612), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Janaury 25-29 and Feb 1, 2016

Feb 23, 2016

The following logs were inspected throughout this inspection; 000533-15, 000539-15, 009482-15, 013583-15, 019478-15, 027252-15, 031583-15. These critical incidents (CI) were reported to the Director, six of the CIs were related to abuse and one was related to a fall.

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, directly observed various meal services, reviewed resident health care records, reviewed staffing patterns and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with The Senior Administrator , the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Staff (RNs and RPNs, Dietitian), RAI/MDS Coordinator, Personal Support Workers (PSW) and the Admission Clerk, residents and family members.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #612 reviewed a Critical Incident (CI) which reported neglect of resident #007 by PSW #105.

In October, 2015, a letter from RN #109 was provided to the Director of Care (DOC) outlining an incident that occurred. RN #109 stated that they noted that resident #007 was not in the dining room during breakfast. They asked PSW #110 where the resident was. PSW #110 told them that resident #007 was assigned to PSW #105; however PSW #105 was off the unit. PSW #110 went to resident #007's room and observed the resident awake, alert and indicated that they were hungry. Staff provided the resident with a breakfast tray. PSW #105 had not provided any report regarding resident #007 to RN #109, the RPN or PSW #110 prior to leaving the unit.

PSW #105 returned to the unit and when questioned by RN #109 why resident #007 was not in the dining room for breakfast, PSW #105 stated that the resident was too sleepy and would not wake up. That was why they did not bring the resident to the dining room. RN #109 indicated to PSW #105 that the resident was awake, alert and hungry and that staff had provided the resident with something to eat.

Under O. Reg. 79/10 neglect is defined as 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.

A review of the home's investigation notes revealed that another letter regarding PSW #105 had been provided to the DOC. A member of the interdisciplinary team reported in the letter, that an interaction had occurred with PSW #105 in October 2015. The member of the interdisciplinary team observed resident #010 being fed by PSW #105. The member of the interdisciplinary team observed that resident #010 had only consumed a portion of their nutritional supplement. When the member of the interdisciplinary team questioned PSW #105, they stated that the resident did not like it. The member of the interdisciplinary team told PSW #105 that they were concerned because resident #010 had lost a significant amount of weight. PSW #105 replied; "good, it is easier to provide them with care that way". The member of the interdisciplinary team recalled that one to two months prior, PSW #105 had approached them and questioned the necessity of the nutritional supplement for resident #010. PSW #105 then made an inappropriate remark about the resident and difficulty providing care for them. The member of the interdisciplinary team provided some teaching to PSW #105 about resident #010's

nutritional intake and that the nutritional supplement helped sustain the resident.

The Inspector interviewed the member of the interdisciplinary team and RN #109; they stated that PSW #105 was removed from resident #010's assignment. This was confirmed by the DOC. The member of the interdisciplinary team stated that no one had provided them with direction to monitor PSW #105; however they were concerned about resident #010's significant weight loss which was why they provided the letter to the DOC.

A review of PSW #105's personnel file revealed the following:

-PSW #105 was provided with a letter of education related to improving their communication with colleagues and registered staff

- Another letter, described that PSW #105 was disciplined related to a serious incident of resident abuse.

Inspector #612 interviewed the DOC on January 26, 2016. The DOC stated that they were "keeping an eye out" for any incidents, concerns or complaints involving PSW #105. The DOC indicated that they felt the PSW had targeted residents that would not be able to recall events due to a cognitive impairment or another medical condition. The DOC did not feel that there was enough evidence to substantiate neglect when the member of the interdisciplinary team provided the letter at the beginning of October, 2015. The DOC confirmed that there were no formal mechanisms in place to monitor PSW #105, despite the incident of substantiated abuse from May, 2014 and the incident where the home provided a letter of education in November, 2014. The DOC stated there was no direction provided to the Registered Staff that supervised PSW #105 on the unit to monitor their interactions with residents.

The Inspector reviewed the home's policy titled Resident Abuse- Staff to Resident, policy reference #OPER-02-02-04, version March 2013. The policy stated to following:

- There is zero tolerance of abuse toward a resident.

- Every person in the home, including staff, has a mandatory and legal obligation to immediately report suspected or witnessed abuse to the Administrator, DOC or their designate who then reported to the Director.

- Resident abuse will result in termination, and, neglect can result in discipline up to an including termination; however, where an act of neglect is determined to fall within the definitions(s) of abuse, e.g resident abuse by neglect, then the result will be termination.

As evidenced by PSW #105's employment record, which included a confirmed incident of abuse in May, 2014, and despite the home's policy, Resident Abuse- Staff to Resident, which stated that confirmed cases of abuse will result in termination, PSW #105 continued to be employed by the home. The licensee has failed to protect residents #010 and #007 from neglect by PSW #105 with a known documented history of abuse and neglect. [s. 19. (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 that all residents are protected from abuse by anyone and are free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that an injury that caused significant change to a resident was reported no later that three business days after the occurrence of the incident.

A Critical Incident, was received by the Ministry of Health and Long-Term Care related to a fall which caused an injury and a significant change to resident #009's health condition.

Resident #009 had an unwitnessed fall, whereby the resident was sent to the hospital because they experienced pain. The resident sustained an injury. The resident returned to the home required a mechanical lift for transfer with the assistance of two staff and extensive assistance for ADL's and mobility. Prior to the fall, resident #009 was independent with transfers and ambulated with an assistive device.

During an interview on January 27, 2015, with Inspector #627, the DOC confirmed that the fall resident #009 sustained had caused an injury and a significant change in the resident's health condition and should have been reported to the Director within three days. [s. 107. (3.1) (b)]

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 any injury that causes a significant change to a resident will be reported no later than three business after the occurrence of 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents are fully respected and promoted, specifically that every resident has the right not to be neglected by the licensee or staff.

A critical incident (CI) was reported to the Director, whereby PSW #114 was allegedly verbally abusive toward resident #003, in the presence of the resident, co-residents and co-workers.

A review of the home's internal investigation revealed that PSW #114 was verbally inappropriate towards resident #003 by speaking to them in a derogatory manner and that they violated the Residents' Rights by failing to respond to their requests for care and rushing through resident care. In a documented interview, a manager asked PSW #114 if they stated that it was not fair that they always had to feed resident #003, because of their behaviours. PSW #114 confirmed making that statement. This PSW also confirmed to the manager in an interview, that it was probably true that they said that they refused to get a resident a glass of water. In a documented conversation between the manager and PSW #114, they acknowledged that their actions and comments were inappropriate.

For the purpose of the Act and Regulations, neglect is defined as 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.

An interview with the manager revealed that PSW #114 was verbally inappropriate by making comments about resident #003 in front of other residents and that this staff member violated the Resident' Bill of Rights. [s. 3. (1) 3.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

Inspector reviewed a Critical Incident (CI) of alleged staff to resident abuse. Resident #006 had reported the incident to a RPN however the name of the RPN was not identified in the report.

A review of resident #006's health care records revealed a progress note completed by RPN #003 which described the incident referred to in the CI report.

Inspector interviewed the DOC who confirmed that RPN #003 was the RPN referred to in the CI report and confirmed that they did not include RPN #003's name in the CI report. [s. 104. (1) 2.]

Issued on this 22nd day of February, 2016

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

Original report signed by the inspector.