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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2018	2018_395613_0011	007595-18	Follow up

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 York
333 York Street SUDBURY ON P3E 5J3

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

LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 17-18, 2018 and May 22-25, 2018.

A Complaint Inspection #2018_395613_0012 and a Critical Incident Inspection # 2018_616542_0013 were completed concurrently with this Follow Up Inspection. Please see the additional reports for further findings of non compliance.

The following intake was completed during this Follow Up inspection:

One Follow up related to CO #001 from Inspection report #2018_657681_0003, s. 20 (1) of the Long-Term Care Homes Act (LTCHA), 2007, for ensuring that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers.

During the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed education and training records and the home's zero tolerance of resident abuse and neglect policies, procedures and programs.

Ad-hoc notes were used during this inspection.

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

1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2018_657681_0003	613

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. 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 policy to promote zero tolerance of abuse and neglect of residents, was complied with.

A complaint was submitted to the Director in February 2018, alleging neglect of resident #003 by staff.

Inspector #627 interviewed resident #003's Substitute Decision-Maker (SDM), who stated that in April 2017, they had received a call from RN #102 informing them that resident #003 had been displaying a specific behaviour. The RN had come to the conclusion that resident #003 had a specific medical condition and would provide a specific intervention. Upon arriving to the home, resident #003 informed the family member/SDM that they had been left unattended during an activity of daily living for a long period of time and that an outsider (not a regular PSW staff member) had been inpatient with them, and had left them unattended during an activity of daily living. The resident had not been able to describe the staff member (PSW), but stated that they were new. Resident #003's SDM stated that they had reported it to RN #102, as they felt this was neglect. They further stated that RN #102 was adamant that the staff had done nothing wrong.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", last updated April 2017, indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unable, to the most senior Supervisor on shift at that time.

A review of the resident's care plan in effect at the time of the alleged incident, indicated

for the focus of the activity of daily living, that resident #003 required extensive assistance from one staff with the activity of daily living.

During an interview with PSW #101, they stated that on the day of the alleged incident, they had found resident #003 in a specific area and was displaying a specific as they had been left unattended during an activity of daily living and had forgotten to ring the call bell. PSW #101 stated that no one had reported to them during shift change report that the resident was in a specific area. The PSW stated that resident #003 usually took a specific amount of time to complete the activity of daily living and should not have been left unattended during the activity of daily living until shift change report was done. PSW #101 stated they had reported it to RN #102, who came right away and spoke to the resident. PSW #101 acknowledged that this was neglect.

During an interview with RN #102, they informed the Inspector that they had no recollection of the incident. They further stated that if a resident had been left unattended during the activity of daily living for a long period of time, then this could be neglect and should have been reported to the ADOC.

During an interview with the DOC, they indicated that they had not been made aware of the alleged incident, which occurred in April 2017. They further stated that when allegations of neglect were brought forth, if there was reasonable grounds and if the PSW suspicions were supported, then the RN should have reported it to the ADOC. The DOC went on to state to the Inspector that staff saw the resident all the time and knew that they had a specific cognitive status and displayed a specific behaviour. The PSW followed the policy and reported it to the RN, who then looked into it. There was further documentation that the resident may have had a specific medical condition, which may have been the cause for displaying the specific behaviour.

During an interview with the Administrator, they stated that at the time of the alleged incident, the home struggled with reporting. They further stated that had resident #003's SDM had a conversation with them and mentioned neglect, it would have been reported to the Ministry right away. Since this time, the registered staff have received extensive training regarding reporting. They must report to the Acting Director of Care (ADOC) any allegations of neglect made by PSW or family members.

No further action will be taken in regards to this non-compliance as compliance order #001 for s. 20 (1) was issued during the Resident Quality Inspection #2018_657681_0003. [s. 20. (1)]

Issued on this 26th day of June, 2018

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

Original report signed by the inspector.