Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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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
Oct 19, 2020	2020_643111_0016	008191-20, 008729-20, 017512-20	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 Port Hope
360 Croft Street PORT HOPE ON L1A 4K8

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

LYNDA BROWN (111)

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): September 28 to 29, 2020.

Three critical incidents reports (CIR) were inspected concurrently during this inspection:
-two CIR's related to falls with an injury for which the resident was taken to hospital.
-one CIR related to alleged staff to resident abuse.

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

During the course of the inspection, the inspector: observed residents, observed resident rooms, reviewed resident health records, reviewed the home's investigations and reviewed the following policies: Zero Tolerance of Resident Abuse and Neglect.

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.
- **2 WN(s)**
- **0 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 :

The licensee failed to ensure that the abuse policy was complied with related to reporting and documentation of verbal abuse and improper care.

Review of the licensee's abuse policy directed that all staff were to immediately notify the Registered Nurse(RN) on-site (or manager) of any alleged or witnessed abuse, document an assessment of the resident, provide support to the resident and complete an incident report.

An RPN submitted an email to the DOC of witnessing a staff to resident abuse incident towards a resident and an improper care incident involving another resident. The RPN did not document the incidents in each resident's progress notes, to indicate the residents were assessed and/or support was provided, no incident report was completed and the email to the DOC was not received until the following day. The Administrator verified that all staff at the home were to immediately notify the RN, the registered staff who became aware of abuse and/or improper care towards residents were to assess the residents involved and document as per the abuse policy.

Sources: CIR, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, progress notes of two residents, risk management reports, the homes internal investigation, interviews with a resident, RN #106 and the Administrator.

WN #2: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's SDM was notified of the results of the investigation into an alleged, staff to resident verbal abuse, upon it's completion.

The Administrator completed an investigation for an alleged, staff to resident verbal abuse and the investigation was concluded a number of days later. The resident was not made aware of the results of the investigation and there was no documented evidence the SDM was notified of the outcome. The Administrator confirmed they could not recall notifying the resident or their SDM of the outcome.

Sources: CIR, a resident's progress notes, home's investigation and interviews with a and the Administrator.

Issued on this 20th day of October, 2020

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

Original report signed by the inspector.