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
Dec 30, 2019	2019_694166_0029	016168-19, 020879-19, 021231-19, 021374-19, 021602-19, 022089-19, 022687-19	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 Haliburton
167 Park Street P.O. Box 780 HALIBURTON ON K0M 1S0

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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

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): December 9, 10, 11, 12 and December 13, 2019.

Critical Incident Reports (CIR):
Log #016168-18, related to medication administration.
Log #020879-19, related to allegations of staff to resident abuse.
Log #021231-19, related to allegations of staff to resident abuse.
Log #022687-19, related to allegations of staff to resident abuse.
Log #021374-19, related to a resident fall.
Log #021602-19, related to allegations of staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behaviourial Support Ontario (BSO) staff member, Dietary Manager, and the Physiotherapist (PT).

During the course of this inspection, the Inspectors observed staff to resident interactions during the provision of care, observed resident to resident interactions, observed a meal service, reviewed specific residents' clinical health records, the licensee's investigation documentation, staff education records, medication administration records, medication incident records and the licensee's policies related to falls, prevention of abuse and medication management.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

4 WN(s)
4 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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Specifically, staff did not comply with the licensee's policy "Zero Tolerance or Resident Abuse and Neglect Program" RC-02-01-01, which directs staff to ensure that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/Designate/Reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

Related to resident #008 and resident #009:

The Director received a Critical Incident Report (CIR) related to allegations of staff to resident abuse.

The CIR described that the DOC received from PSW #108, a witnessed allegation of abusive behaviours by PSW #109 directed towards residents in the home.

Review of the licensee's internal investigation was completed by Inspector #194. The internal investigation, concluded that allegations of abuse by PSW #109 towards residents had been founded.

During an interview with Inspector #194, the DOC indicated, PSW #108 reported the allegations of abuse by PSW #109, directed towards resident #009 and resident #008. The DOC confirmed PSW #108 had previously reported the incidents to RN #110.

During a telephone interview with Inspector #194, PSW #108 indicated, they had witnessed, PSW #109 being abusive towards resident #008. PSW #108 also indicated witnessing PSW #109, threatening resident #009.

PSW #108 also indicated that PSW #109 was rough when providing care, no specific residents were identified. PSW #108 indicated the abusive behaviour from PSW #109 was witnessed and that the incidents had been reported to RN #110.

Related to resident #014:

The Director received a Critical Incident Report (CIR) for allegations of staff to resident abuse.

The CIR described that, PSW #111 reported to RPN #106, witnessing abuse by PSW #112, directed towards resident #014. RPN #106 immediately reported to the DOC, the Director and an investigation was initiated.

Review of the licensee's internal investigation was completed by Inspector #194. The internal investigation, indicated that PSW #112 had resigned before the licensee could get a statement. Review of the progress notes for resident #014, indicated that BSO/RPN #105, had documented a summary of the incident involving resident #014.

During an interview with Inspector #194, the DOC indicated, PSW #111 had reported the allegations of abuse by PSW #112 directed towards resident #014 to RPN #106 on the date of the incident. PSW #111 ensured that resident #014 remained safe at the time of the incident.

During an interview with Inspector #194, PSW #111 indicated that they had witnessed PSW #112 verbally and emotionally abusive towards resident #014 during the provision of care. PSW #111 described, they had overheard PSW #112 and resident #014 arguing in the resident's room.

During an interview with Inspector #194, BSO/RPN #105, explained that the progress notes in the resident's chart were written by the BSO/RPN #105 and was a summary of what was reported to them by the PSW staff, involved in the incident. BSO/RPN #105 had not witnessed the incident.

The licensee has failed to ensure it's "Zero Tolerance of Resident Abuse and Neglect Program" was complied with:
1.When PSW #111 did not immediately report the witnessed abuse of resident #014 by PSW #112 to the Charge Nurse and when RPN #105, did not report the allegations to the Charge Nurse, after PSW #111 had discussed the incident with RPN #105.

2. When PSW #108 did not immediately report the allegations of staff to resident abuse directed towards resident #008, #009 and other unnamed residents by PSW #109 to RN #110. [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 licensee's written policy to promote zero tolerance of abuse and neglect of residents, related to reporting is complied with, 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 :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Related to resident #008 and resident #009:

The Director received a Critical Incident Report (CIR) related to allegations of staff to resident abuse. The CIR described that the DOC had received from PSW #108, a witnessed allegation of abusive behaviours by PSW #109, directed towards residents in the home.

Review of the licensee's internal investigation was completed by Inspector #194. The licensee's internal investigation, concluded that allegations of abuse by PSW #109 towards residents had been founded.

During a telephone interview with Inspector #194, RN #110 indicated that PSW #108 had reported allegations of staff to resident abuse by PSW #109, towards residents at the home. RN #110 indicated to Inspector #194, that they could not remember the exact date of the reported allegations. RN #110 indicated that the allegations were not immediately investigated when reported by PSW #108.

During an interview with Inspector #194, the DOC indicated that PSW #108 reported allegations of abuse by PSW #109 directed towards resident #009 and resident #008,these incidents had occurred a few weeks earlier and had been reported to RN #110 by PSW #108.

The licensee failed to ensure that the allegations of staff to resident abuse by PSW #109, reported to RN #110, by PSW #108 were immediately investigated. [s. 23. (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, every alleged, suspected or witnessed incident of resident abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #3: 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 failed to ensure that any person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident immediately report the suspicions and the information upon which it is based to the Director.

The Director received a Critical Incident Report (CIR) for allegations of staff to resident, physical, verbal and emotional abuse. The CIR described that the DOC received an allegation of abuse from PSW #108, for witnessed abusive behaviours by PSW #109, towards residents in the home.

Review of the licensee's internal investigation was completed by Inspector #194. The licensee's internal investigation, concluded that allegations of abuse by PSW #109 towards residents had been founded.

During a telephone interview with Inspector #194, RN #110 indicated that PSW #108 had reported the allegations of abuse by PSW #109, towards residents at the home. RN #110 indicated to Inspector #194, that they could not remember the exact date of the reported allegations. RN #110 indicated that they had also witnessed PSW #109 being rough while providing care to residents at the home in the past.

RN #110 stated, the witnessed staff to resident abuse and the allegations of abuse reported by PSW #108, involving PSW #109, were not immediately reported to the Director.

During an interview with Inspector #194, the DOC indicated, PSW #108 had reported the allegations of staff to resident abuse, directed towards resident #009 and resident #008, by PSW #109. The allegations of staff to resident abuse had also been previously reported to RN #110 by PSW #108.

The licensee failed to ensure allegations of abuse were immediately reported to the Director, when PSW #108 reported the allegations of staff to resident abuse involving PSW #109 to RN #110. [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 a person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed no later than one business day after the occurrence of a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

Related to resident #013:

A Critical Incident Report (CIR) was submitted to the Director, reporting a medication incident. Resident #013 was administered a double dose of a specific medication and was transferred to the hospital for further assessment.

Review of resident #013's, health records documented by RN #104, related to the date of the incident, by Inspector #166, indicated that resident #013 had requested their medication from RPN #102. The RPN administered the medication.

Later that same date, RN #104, also administered resident #013's medication, which included the specific medication, as the medications given earlier by RPN #102 had not been signed off as been administered.

The licensee has failed to ensure the Director was informed no later than one business day after the occurrence of a medication incident which caused resident #013 to be transferred to the hospital for further assessment. The Director was notified five business days post incident. [s. 107. (3)]

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 Director is informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report.; A medication incident or adverse drug reaction in respect of which a resident is taken to hospital, to be implemented voluntarily.

Issued on this 6th day of January, 2020

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

Original report signed by the inspector.