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
Sep 18, 2017	2017_687607_0015	001366-17, 004675-17, 008631-17, 009601-17, 012216-17, 015609-17	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 KAWARTHA LAKES
125 Colborne Street East LINDSAY ON K0L 2V0

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

JULIET MANDERSON-GRAY (607)

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): August 3, 4, 8, 9 and 10, 2017

During the Critical Incident Inspection the following intakes were inspected: Log #’s 012216-17, 004675-17, 015609-17, 008631-17, 008631-17, 009601-17 and 002548-17.

Summary of Intake Logs:
1) 012216-17: A Critical Incident Report (CIR) regarding an alleged staff to resident neglect.
2) 004675-17: A CIR, regarding an alleged staff to resident abuse.
3) 015609-17, 008631-17, 009601-17: CIRs, regarding alleged resident to resident abuse.

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

During the course of the inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed training records and home specific policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
6 VPC(s)
1 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 are protected from abuse by anyone.

Under O.Reg.79/10, s. 2(1) for the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to Log’s #015609-17, 008631-17 and 009601-17 involving resident #002 and #003:

Three Critical Incident Reports (CIR) were submitted to the Director on separate identified dates and times for incidents of resident to resident abuse involving resident #002 and #003. The CIRs indicated resident #003 exhibited non-consensual responsive behaviours directed towards resident #002. The CIRs further indicated that resident #003 is profoundly impaired and is unable to consent. The CIR also indicated that resident #002 has been on increase monitoring since an identified date, due to the resident demonstrated responsive behaviours that were directed towards an unidentified resident in the past.

A review of resident #002’s Progress Notes for a seven month period, indicated there was no documented evidence that resident #002 and #003 were assessed after each incident of exhibited responsive behaviours, to indicate that both residents were able to consent. Further review of the Progress Notes for resident #002, indicated there were four incidents of identified responsive behaviours involving resident #002 and #003.

During an interview, RPN #105 indicated that two identified incidents of responsive behaviours were not reported to the RN in charge of the home nor the Director of Care.

During interviews with Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #005, all indicated that resident #002 is able to remove a monitoring device intervention put in place, to alert staff that the resident was moving from an identified area. The RPN further indicated, that the interventions in the written plan of care were not effective in managing the resident's identified responsive behaviours.

During an interview, the DOC indicated not being aware of two of the identified incidents that occurred on two separate identified dates related to resident #002 and #003, thus they were not reported to the Director. During the same interview the DOC indicated, that neither residents (#002 and #003) had a capacity assessment completed to determine, if the residents had the capacity to consent. The DOC also indicated resident #003 was not able to consent to identified responsive behaviours involving resident #002.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1. The licensee does not have a history of non-compliance with LTCHA, 2007 S.O. 2007, c 8, s.19, however, there is evidence of ongoing identified responsive behaviours involving resident #003 and #002. Based on the scope and severity concerns involving both residents, a Compliance Order was warranted as follows.

2. The licensee failed to ensure that care set out in the plan of care provided to the resident #002 as specified in the plan, specifically related to not ensuring nursing staff was in place on an identified date, to provide increase monitoring of resident #002, which resulted in the resident engaging identified responsive behaviours with resident #003, as identified under O. Reg. 79/10, s. 6 (7). (Refer to WN #02).

3. The licensee has failed to ensure when resident #002 was reassessed, the plan of care was revised because the care set out in the plan had not been effective, and different approaches have been considered. The plan of care was not revised, specifically related to resident #002 being able to remove interventions that were put in place, to alert staff when the resident was leaving an identified area, as identified under O. Reg. 79/10, s. 6 (11)(b). (Refer to WN #02).

4. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, specifically related to the identified incidents of responsive

behaviours on three identified dates, involving resident #002 and #003, as identified under O. Reg. 79/10, s.23 (1). (Refer to WN #03).

5. The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically related to not reporting an alleged resident to resident responsive behaviour, involving resident #002 and #003 an identified date, immediately to the Director, as identified under O. Reg. 79/10, s.24 (1). (Refer to WN #04).

6. The licensee has failed to ensure its Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 was complied with, specifically related to when RPN #105 became aware of alleged, suspected or witnessed resident to resident incident of responsive behaviours involving resident #002 and #003, the incidents were not reported immediately to the Administrator/designate/reporting Manager or if unavailable, to the most senior supervisor on shift at that time, as well as, there were four incidents of either suspected and/or witnessed incidents of resident to resident abuse that occurred on four identified dates, where there was no documented evidence the recipient residents SDM's were notified of the incidents, as identified under O. Reg. 79/10, s.20 (1). (Refer to WN #08).

7.The SDMs of Resident #002 and #003 were not always notified of the suspected or witnessed abuse, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #06).

8. All of the suspected or witnessed incidents of resident to resident abuse were not reported to the police, as identified under O.Reg.79/10, s.98. (Refer to WN #07). [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed ensure that there is a written plan of care for each resident #001 sets out, the planned care for the resident.

Related to Intake Log # 001366-17 involving resident #001:

A CIR was submitted to the Director on an identified date for an incident of an alleged staff to resident abuse that occurred on an identified date and time. The CIR indicated that resident #001's Substitute Decision Maker (SDM) accused staff of causing harm to the resident.

A review of the Progress Notes for resident #001 on an identified date, indicated there were multiple incidents of demonstrated responsive behaviours, involving resident #001.

Observation of resident #001 during the inspection indicated the resident is cognitively impaired and mobilizes with mobility device with the assistance of staff.

During interviews, PSW #120 and #112, both indicated that resident #001 exhibited several identified responsive behaviours. The PSWs indicated that when the resident exhibited these behaviours, they would ensure that the resident was safe, re-approach and report to the nurse right away.

During an interview, RPN #117 indicated that resident #001 exhibits several identified responsive behaviours.The RPN further indicated that the resident has identified triggers, that includes language barrier. RPN #117 indicated, that when resident #001 exhibits these behaviours, the staff would redirect the resident, use a special therapy and get to the resident's level to communicate with the resident. The RPN further indicated there were no interventions in the resident's written plan of care to direct staff how to manage the resident's behaviour.

A review of resident #001's written plan of care related to responsive behaviours identified two interventions that were in place, and of the two interventions identified, non were related to the triggers and responsive behaviours identified by RPN #117 and PSWs #120 and #112.

The written plan of care did not identify responsive behaviours identified by PSWs #112, #120 and RPN #117. The plan of care was not revised to include the identified responsive behaviours or related triggers despite the resident demonstrating ongoing identified responsive behaviours. The plan of care did not include interventions of how staff were to manage these responsive behaviours.

During an interview with the Director of Care, the DOC indicated that interventions for responsive behaviours must be included in the written care plan.

The licensee failed to ensure that the written plan of care sets out the planned care for resident #001, as the plan of care failed to indicate that when resident #001 demonstrated responsive behaviours towards staff and residents, the behaviours were identified in the written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that care set out in the plan of care is provided to resident #002 as specified in the plan.

Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date and time for an allegation of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) discovered resident #003 and #002 exhibiting responsive behaviours.

A review of resident #002’s written plan of care related to responsive behaviours indicated there were several interventions in place, that includes nursing staff to provide increase monitoring of the resident.

During an interview with Registered Practical Nurse (RPN) #105, the RPN indicated that on an identified date when the incident occurred, there should have been a staff member available to provide increase monitoring of resident #002. The RPN also indicated, that the home was unable to provide nursing staff for increase monitoring of resident #002 on the day of the incident.

During an interview with the Director of Care, the DOC indicated that neither residents (resident #002 and #003) had a capacity assessment completed to determine, if the residents were able to consent to identified responsive behaviours. The DOC further indicated, that care was not provided according to the plan of care, as the home was unable to provide nursing staff for increase supervision of resident #002 on the identified date when the incident occurred.

The licensee failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan, specifically related to not ensuring a nursing staff was available to provide increase monitoring of resident #002, resulting in resident #002 engaging identified responsive behaviours with resident #003. [s. 6. (7)]

3. The licensee has failed to ensure that when resident #002 was being reassessed, the plan of care was revised, because the care set out in the plan had not been effective, and different approaches were considered in the revision of the plan of care

Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date for an allegation of resident to resident abuse. The CIR indicated that a PSW discovered resident #003 in an identified area exhibiting responsive behaviours that were directed towards resident #002.

A review of the Progress Notes for a specified six month time period, indicated there were multiple incidents of resident to resident responsive behaviours involving resident #002 and #003, where resident #002 was able to remove interventions put in place to decrease exhibited responsive behaviours.

On an identified date and time, resident #002 was observed by the Inspector, in an identified area without interventions in place, as per care plan.

A review of resident #002’s written plan of care, related to responsive behaviours indicated the resident had several interventions in place, that included ensuring that a monitoring device was in place at all times and activated.

During an interview with PSW #104 and RPN #105, the RPN indicated that resident #002 was able to deactivate the monitoring device, and further indicated that the interventions in the written plan of care were not effective in managing the resident's identified responsive behaviours.

During an interview with the Director of Care (DOC), the DOC indicated, that the licensee's expectation is that when the care set out in the plan of care is not effective, the plan of care should be updated/revised.

The licensee has failed to ensure when resident #002 was reassessed, the plan of care was revised because the care set out in the plan had not been effective, and different approaches had not been considered. The plan of care was not revised, specifically related to resident #002 being able to deactivate a monitoring device that was in place to alert staff, when the resident was leaving an identified area. [s. 6. (11) (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 ensuring that there is a written plan of care for resident #001, sets out the planned care for the resident, to be implemented voluntarily.

WN #3: 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 has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated.

Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date and time, for an allegation of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) discovered resident #003 and #002 exhibiting identified responsive behaviours.

Review of the Progress Notes for resident #002 for a specified 12 month period, indicated there were four incidents of either witnessed or suspected resident to resident responsive behaviours by resident #002 directed towards resident #003.

There was no evidence in the progress notes following the incidents of alleged suspected or witnessed identified responsive behaviours by resident #002 directed towards other residents were investigated.

During an interview with RPN #105 indicated, he/she did not report the identified incidents to the Director of Care as they were already written in the Progress Notes.

During an interview with the Director of Care (DOC) indicated, that he/she reviewed the Progress Notes on a daily basis, and further indicated the above identified incidents were not investigated.

The licensee has failed to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone that the licensee knows of, or that was reported immediately, were investigated, specifically related to two identified incidents involving resident #002 and #003. [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 ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated, specifically related to resident #002 and #003, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date and time for an allegation of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) discovered resident #003 in an identified area exhibiting responsive behaviours towards resident #002.

During an interview, RPN #105 indicated he/she reported the above identified incident to the DOC, immediately upon becoming aware.

During an interview, the DOC indicated he/she became aware of the incident on the date the incident occurred, and after reading the Progress Notes on the following day, he/she had realized that the incident should have been immediately reported to the Director, and this was not done.

The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically related to the reporting an alleged resident to resident responsive behaviour involving resident #002 and #003. [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 ensuring that a person who has reasonable grounds to suspect that abuse has occurred or may occur of a resident by anyone that resulted in harm or a risk of harm to the resident, shall immediately report the suspicion and the information upon, which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents

Related to Intake Log #004675-17 involving resident # 004:

A CIR was submitted to the Director on an identified date and time. The CIR indicated that on an identified date and time, resident #004 sustain injuries to a body part, during a transfer involving a Personal Support Worker.

The clinical health record for resident #004, was reviewed by the Inspector on an identified date and time, and identified that there were several interventions in place related to falls and transfers. Further review of the Progress Notes for resident #004 indicated that the resident sustained several injuries related to a transfer on an identified date.

During an interview on an identified date and time with resident #004 indicated, that at the time of the above identified incident, PSW #109 was assisting the resident with a transfer, when the PSW asked the resident to move to a certain position. The resident indicated that he/she told the PSW that he/she was unable to move. The PSW

attempted to transfer the resident while the resident was not in a weight bearing position, which resulted in both the resident and the PSW #109 falling.

During an interview with PSW #107 indicated, that he/she had cared for resident #004 on the date after the incident occurred, and noted there were injuries to the resident. Personal Support Worker #107 indicated that resident #004 had indicated to him/her, that PSW #109 was performing a transfer while the resident was not in a weight bearing position, resulted in the resident being hurt. The PSW indicated that resident #004 had asked numerous times that PSW #109 not care for him/her, and this was reported to an unidentified registered staff member.

During an interview with PSW #109 indicated, that at the time of the incident he/she was transferring the resident from a one area to another, and did not realize the resident was not in weight bearing position, prior to the transfer.

During an interview, RPN #106 indicated learning of the injuries to resident #004 the next day. RPN #106 indicated that he/she took resident #004 to the DOC to report the above identified incident.

During an interview, the DOC indicated that at the time of the incident PSW #109 rushed the care of resident #004, which resulted in injuries to the resident.

A review of the written care plan on an identified date, after the above identified incident, indicated resident #004 was reassessed and now requires two staff assistance, for transfers and the use of a mechanical device when required.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #004 by not ensuring the resident body parts were in a weight bearing position, prior to transferring the resident, which resulted in the resident sustaining injuries. [s. 36.]

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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, specifically related to resident #004, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date and time for an allegation of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) discovered resident #003 in an identified area exhibiting identified responsive behaviours that were directed towards resident #002.

During an interview with the DOC indicated that resident #003 is cognitively impaired. During the same interview, the DOC indicated that neither residents had a capacity assessment completed to determine, if the residents were able to consent and further indicated that resident #003 does not have the capacity to consent to identified responsive behaviours. The DOC indicated becoming aware of the above identified incident on an identified date, involving resident #002 and #003. The DOC also indicated the Substitute Decision Makers (SDM) for both residents were not notified immediately, of the above identified incident of resident to resident responsive behaviours [s. 97. (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 ensuring that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse, specifically related to resident #002 and #003, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence

Related to Intake Log #015609-17 involving resident #002 and #003:

Review of the Progress Notes for resident #002 indicated for a 12 month period, indicated there were ongoing incidents of either witnessed or suspected identified responsive behaviours by resident #002 directed towards resident #003 as follows:

- There were two incidents of either suspected and/or witnessed incidents of resident to resident responsive behaviours that occurred on two identified dates and there were no documented evidence that the police was notified of the incidents (See WN #02).

During an interview with RPN #105, the RPN indicated that the police was not notified of the incidents that occurred on identified dates.

During an interview with the Director of Care, the DOC indicated that the police was not notified of the identified incidents of resident to resident responsive behaviours. [s. 98.]

2. Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date and time for an allegation of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) discovered resident #003 in an identified area exhibiting responsive behaviours that were directed towards resident #002.

During an interview, the DOC indicated that neither residents had a capacity assessment completed to determine, if the residents were able to consent. Further interview with the DOC indicated RPN #105 reported the above identified incident to him/her on the date it occurred, and indicated that the incident was not reported to police until the next day.

The licensee failed to ensure that the appropriate police force was immediately notified of above identified alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, specifically related to resident #002 and #003. [s. 98.]

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 ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #8: 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 its Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 was complied with.

Related to Intake Log #015609-17 involving resident #002 and #003:

A CIR was submitted to the Director on an identified date and time for an allegation of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) discovered resident #003 in an identified area exhibiting identified responsive behaviours towards resident #002.

A review of the licensees Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 (Pg. 2/4) directs:

Reporting
1. Any employee or person who becomes aware of an alleged, suspected or witnessed resident to 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.

Review of the Progress Notes for resident #002 for a 12 month period, indicated there were two incidents of either witnessed or suspected resident to resident abuse by resident #002 that were directed towards resident #003, that were identified, and had no documented evidence to indicate the Director was notified of the resident to resident alleged and/or suspected abuse:

During an interview, RPN #105 indicated that the above identified incidents were not reported to the RN in charge of the home nor the Director of Care.

During an interview, the DOC indicated not being aware of the above identified incidents of abuse, thus they were not reported to the Director.

The licensee has failed to ensure its Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 was complied with, specifically related to when RPN #105 became aware of alleged, suspected or witnessed resident to resident incidents of abuse involving resident #002 and #003. The incidents were not reported immediately to the Administrator/designate/reporting Manager or if unavailable, to the most senior supervisor on shift at that time. [s. 20. (1)]

2. Related to Intake Log #'s 015609-17, 008631-17 and 009601-17 involving resident #002 and #003:

A review of the licensees Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 (Pg. 2-3 of 4) directs:

Reporting
1. Any employee or person who becomes aware of an alleged, suspected or witnessed resident to 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.
5. Disclosure of the alleged abuse will be made to the resident/Substitute Decision Maker (SDM)/Power of Attorney (POA), immediately upon becoming aware of the incident, unless the SDM/POA is alleged perpetrator.

Review of the Progress Notes for resident #002 for a 12 month period, indicated there

were four incidents of either witnessed or suspected resident to resident responsive behaviours by resident #002 directed towards resident #003, and there was no documented evidence the recipient residents SDM's were notified of the incidents. (See WN #02).

During an interview, RPN #105 indicated that resident #002 or #003's Substitute Decision Makers (SDM) were not notified of the above incidents.

The licensee has failed to ensure its Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 was complied with, specifically related to not disclosing incidents of alleged abuse involving resident #002 and #003 to the resident/Substitute Decision Maker (SDM)/Power of Attorney (POA), immediately upon becoming aware of the incident. [s. 20. (1)]

Issued on this 20th day of September, 2017

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2017_687607_0015
Log No. / No de registre :	001366-17, 004675-17, 008631-17, 009601-17, 012216-17, 015609-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 18, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE KAWARTHA LAKES 125 Colborne Street East, LINDSAY, ON, K0L-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Rooney

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that:

1. All members of the management team of the home, including Registered Nurses and Registered Practical Nurses are educated on:

The Long-Term Care Act, 2007 (LTCHA) and Ontario Regulation (O. Reg.) 79/10, specifically related to the following sections:

LTCHA s.24 – Reporting certain matters to the Director
LTHCA s.23 – Licensee must investigate, respond and act
LTHCA s.20 – Policy to promote zero tolerance
O. Reg. 79/10 s. 2 - Definition of abuse
O. Reg. 79/10 s. 97 – Notification re incidents
O. Reg. 79/10 s. 98 – Police notification

2. A process is developed and put in place whereby the Director of Care and/or delegates are reviewing all documentation and communication from the front line staff at least daily to determine if any resident abuse has occurred in the home; and this shall continue until compliance is achieved.

3. If any person has reasonable grounds to suspect that resident abuse of any kind have occurred, including any suspicions, allegations or witnessed incidents of abuse, the licensee will immediately investigate and ensure that appropriate actions are taken as per legislative requirements.

4. Every resident currently exhibiting responsive behaviours, which may lead to abusive situations is assessed, the incidents and assessments are documented,

and the plan of care is reviewed and revised, including, but not limited to the plan of care of resident #002 and #003, until effectiveness strategies are identified and implemented.

5. The licensee`s "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", policy # RC-02-01-02 is complied with, including but not limited to requirements related to reporting to the Director, the SDM notification and police notification.

The plan shall be submitted on or before September 29, 2017 to LTCH Inspector-Nursing Juliet Manderson-Gray via fax at 613-569-9670 or via email at OttawaSAO.MOH@ontario.ca. The plan shall identify who will be responsible for each items and expected completion dates.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Under O.Reg.79/10, s. 2(1) for the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to Log's #015609-17, 008631-17 and 009601-17 involving resident #002 and #003:

Three Critical Incident Reports (CIR) were submitted to the Director on separate identified dates and times for incidents of resident to resident abuse involving resident #002 and #003. The CIRs indicated resident #003 exhibited non-consensual responsive behaviours directed towards resident #002. The CIRs further indicated that resident #003 is profoundly impaired and is unable to consent. The CIR also indicated that resident #002 has been on increase monitoring since an identified date, due to the resident demonstrated responsive behaviours that were directed towards an unidentified resident in the past.

A review of resident #002's Progress Notes for a seven month period, indicated there was no documented evidence that resident #002 and #003 were assessed after each incident of exhibited responsive behaviours, to indicate that both residents were able to consent. Further review of the Progress Notes for

resident #002, indicated there were four incidents of identified responsive behaviours involving resident #002 and #003.

During an interview, RPN #105 indicated that two identified incidents of responsive behaviours were not reported to the RN in charge of the home nor the Director of Care.

During interviews with Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #005, all indicated that resident #002 is able to remove a monitoring device intervention put in place, to alert staff that the resident was moving from an identified area. The RPN further indicated, that the interventions in the written plan of care were not effective in managing the resident's identified responsive behaviours.

During an interview, the DOC indicated not being aware of two of the identified incidents that occurred on two separate identified dates related to resident #002 and #003, thus they were not reported to the Director. During the same interview the DOC indicated, that neither residents (#002 and #003) had a capacity assessment completed to determine, if the residents had the capacity to consent. The DOC also indicated resident #003 was not able to consent to identified responsive behaviours involving resident #002.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1. The licensee does not have a history of non-compliance with LTCHA, 2007 S.O. 2007, c 8, s.19, however, there is evidence of ongoing identified responsive behaviours involving resident #003 and #002. Based on the scope and severity concerns involving both residents, a Compliance Order was warranted as follows.

2. The licensee failed to ensure that care set out in the plan of care provided to the resident #002 as specified in the plan, specifically related to not ensuring nursing staff was in place on an identified date, to provide increase monitoring of resident #002, which resulted in the resident engaging identified responsive behaviours with resident #003, as identified under O. Reg. 79/10, s. 6 (7). (Refer to WN #02).

3. The licensee has failed to ensure when resident #002 was reassessed, the

plan of care was revised because the care set out in the plan had not been effective, and different approaches have been considered. The plan of care was not revised, specifically related to resident #002 being able to remove interventions that were put in place, to alert staff when the resident was leaving an identified area, as identified under O. Reg. 79/10, s. 6 (11)(b). (Refer to WN #02).

4. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, specifically related to the identified incidents of responsive behaviours on three identified dates, involving resident #002 and #003, as identified under O. Reg. 79/10, s.23 (1). (Refer to WN #03).

5. The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically related to not reporting an alleged resident to resident responsive behaviour, involving resident #002 and #003 an identified date, immediately to the Director, as identified under O. Reg. 79/10, s.24 (1). (Refer to WN #04).

6. The licensee has failed to ensure its Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, policy # RC-02-01-02 was complied with, specifically related to when RPN #105 became aware of alleged, suspected or witnessed resident to resident incident of responsive behaviours involving resident #002 and #003, the incidents were not reported immediately to the Administrator/designate/reporting Manager or if unavailable, to the most senior supervisor on shift at that time, as well as, there were four incidents of either suspected and/or witnessed incidents of resident to resident abuse that occurred on four identified dates, where there was no documented evidence the recipient residents SDM's were notified of the incidents, as identified under O. Reg. 79/10, s.20 (1). (Refer to WN #08).

7.The SDMs of Resident #002 and #003 were not always notified of the suspected or witnessed abuse, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #06).

8. All of the suspected or witnessed incidents of resident to resident abuse were not reported to the police, as identified under O.Reg.79/10, s.98. (Refer to WN #07). [s. 19. (1)] (607)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 20, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of September, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Juliet Manderson-Gray

Service Area Office / Bureau régional de services : Ottawa Service Area Office