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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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 14, 2018	2018_617148_0037	025162-17, 027372-17, 010170-18, 029335-18	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 New Orchard Lodge
99 New Orchard Avenue OTTAWA ON K2B 5E6

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

AMANDA NIXON (148)

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): November 27, 28, 29 and 20, 2018

This inspection included four critical incident reports (CIR): three related to alleged resident physical, emotional and/or verbal abuse (Log 025162-17/ CIR #2302-000027-17, Log 010170-18/ CIR #2302-000008-18 and Log 029335-18/ CIR #2302-000014-18); and one related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health condition (Log 027372-17/ CIR #2302-000028-17).

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Office Manager, Resident Program Manager, Registered Nurses (RN), Registered Practical Nurses, Personal Support Workers (PSW), Activity Aide, visitors and residents.

The Inspector also reviewed resident health care records and documents related to the licensee's investigation into alleged incidents of abuse. In addition, the Inspector observed resident and staff interaction, the residents care environment and video footage of an alleged abuse incident.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with section 2(1) of Regulations 79/10, physical abuse means, the use of physical force by a resident that causes physical injury to another resident; emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident; and verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A progress note, written by RN #107, described that a visitor reported that an altercation between resident #003 and resident #005. Upon assessment the RN discovered an injury on resident #005; there was no injury to resident #003.

During an interview with Inspector #148, RN #107 indicated that this incident was not

abuse, as neither resident could identify who had instigated the altercation. Furthermore, RN #107 reported that the incident was not abuse as resident #003 was not cognitively aware of resident #003's actions and would not hurt someone on purpose. The Inspector spoke with the home's DOC #102 who reported that it was likely resident #005 had instigated the altercation and as resident #005 was the one who was injured the incident would not be considered abuse.

This incident of alleged physical abuse became known to the Director during an inspection of resident #003, on November 27, 2018. Prior to this date, no report had been made to the Director related to this incident of alleged physical abuse.

A critical incident report was submitted to the Director on a specified date, describing that four days prior, Activity Aide #109 witness PSW #110 to use physical force on resident #004 and then proceed to inhibit the resident's movement; the PSW was heard to speak to the resident inappropriately using profanity. Activity Aide #109 indicated that on the date of the incident, the Activity Aide reported the incident observed to someone in the building, however, could not recall to whom the report had been made. The Activity Aide reported that on the next scheduled shift, confirmed as two days after the incident, the Activity Aide reported the incident to the Resident Program Manager. In an interview with the Resident Program Manager, it was reported that Activity Aide #109 did approach the manager with the report two days after the incident, at which time the Resident Program Manager reported the incident to the DOC #111, who was in the position at that time. During an interview with the home's Administrator it was reported that the Administrator was informed of the incident four days after the incident; at which time the licensee initiated an investigation into the incident and made a report to the Director.

The incident of alleged emotional and verbal abuse, was not immediately reported to the Director, rather was reported four days after the incident had occurred.

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 ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 17th day of December, 2018

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

Original report signed by the inspector.