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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 2013	2013_196157_0021	000859-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE, PETERBOROUGH, ON, K9J-6B4

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 15, 16, 17, 24, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered nursing staff

During the course of the inspection, the inspector(s) reviewed the clinical health record of an identified resident, reviewed the licensee's incident investigation records, reviewed licensee policies related to the management of complaints, the management of resident incidents, notification of family and resident abuse, reviewed the licensee's staff education records, reviewed the licensee's Quality Evaluation Program related to Resident Abuse.

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

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to submit a report to the Director when there were reasonable grounds to suspect abuse of an identified resident:
- with respect to the suspected abuse of the resident
- indicating a description of the individuals involved
- indicating actions taken in response to the incident
- indicating an analysis of the incident or follow up action taken
- indicating the name and title of the person making the report to the Director

The licensee failed to ensure that the alleged abuse of the identified resident was immediately investigated and that appropriate action was taken in response to the allegations

On an identified date, the Administrator received a written complaint outlining concerns about the care of an identified resident and injuries of unknown origin.

1. There is no evidence that action was taken at any time to investigate the cause of the resident's identified injuries.[s. 23. (1) (a)]

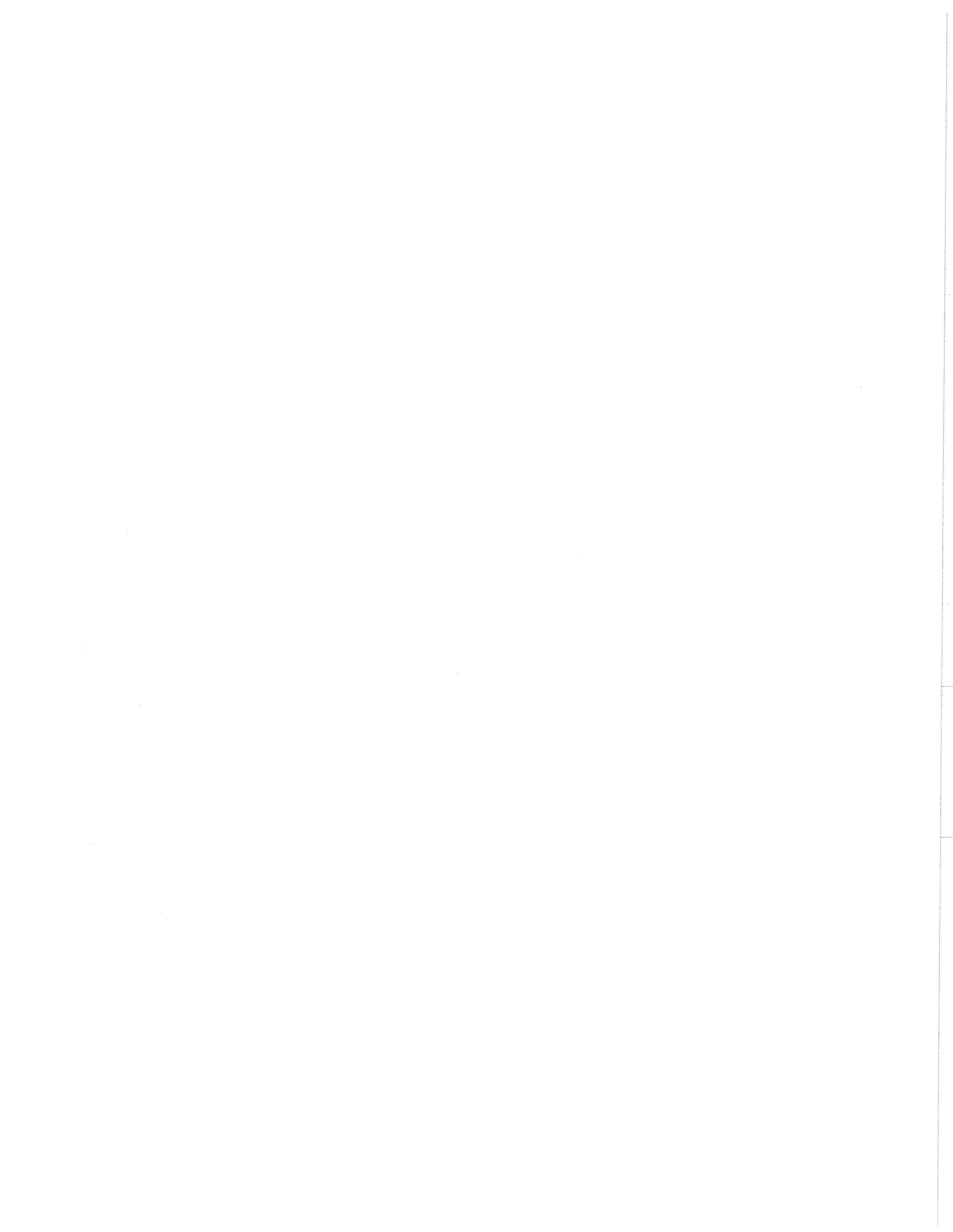
2. There is no evidence that appropriate action was taken in response to an identified resident's injuries of unknown origin when the licensee became aware of them.[s. 23. (1) (b)]

3. The licensee has acknowledged that an abuse investigation was not completed and therefore the results of such an investigation were not reported to the Director. [s. 23. (2)]

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 abuse is immediately investigated, that appropriate action is taken in response to every such incident and that the results of every such investigation undertaken are submitted to the Director, to be implemented voluntarily.

WN #2: 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).

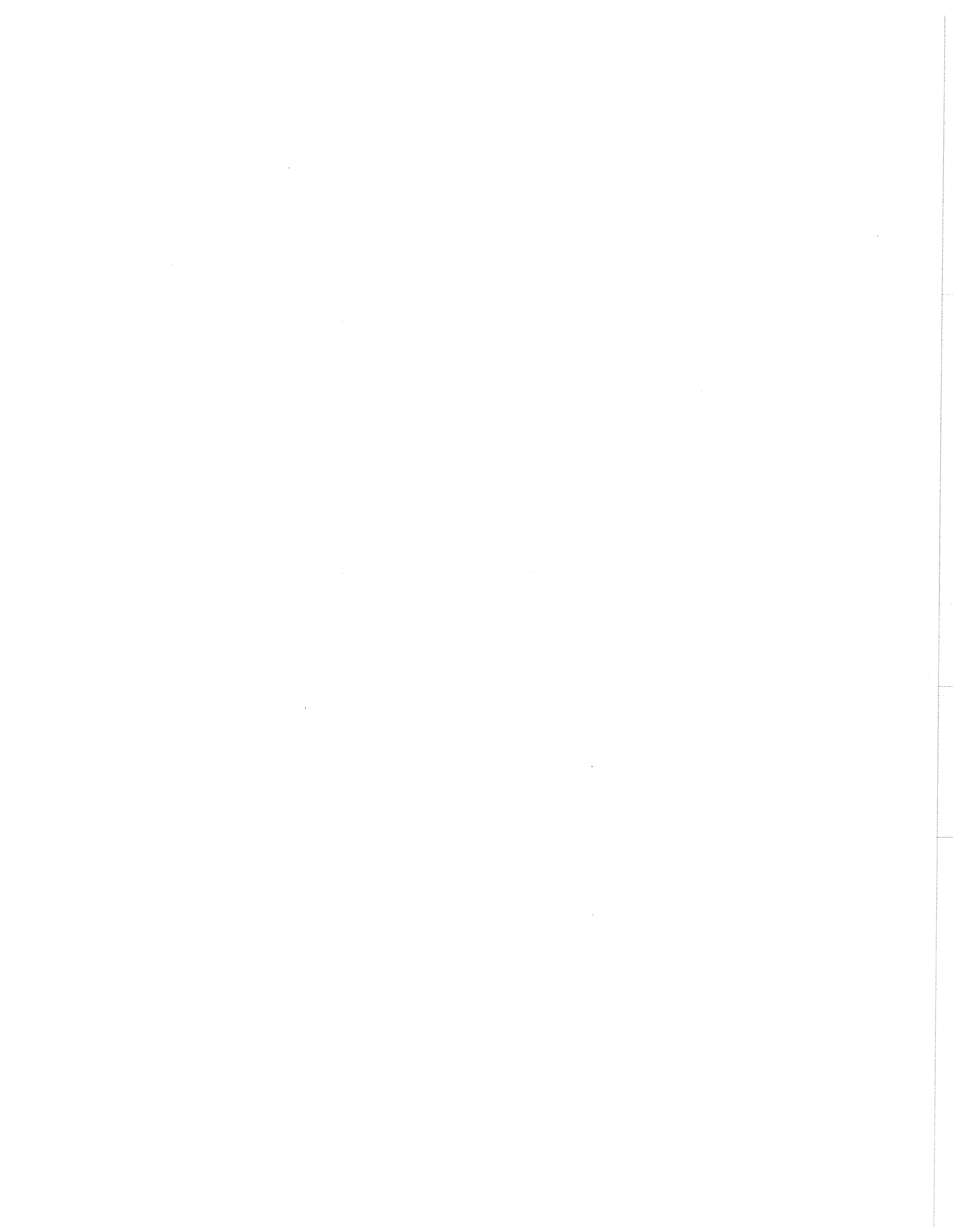
Findings/Faits saillants :

1. The licensee failed to immediately report the suspicion of abuse of an identified resident and the information upon which was based to the Director.

The Administrator received a written complaint related to the care of the resident and injuries of an unknown origin.

Progress notes for the resident indicate the resident exhibited injuries of an unknown origin.[s. 24. (1)]

2. The licensee had reasonable grounds to suspect abuse of an identified resident which resulted in harm to the resident. A report was not submitted to the Director. [s. 24. (1)]

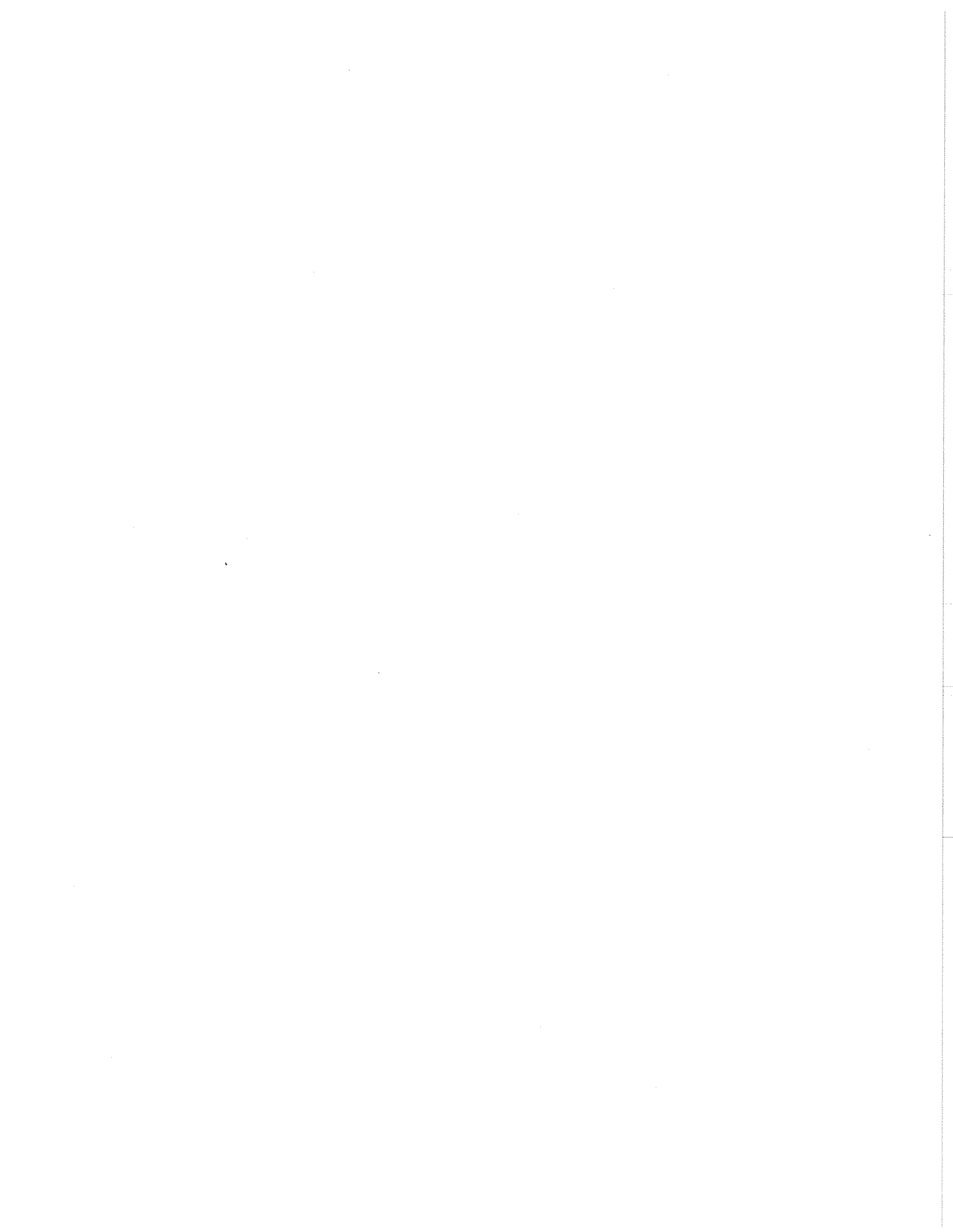


Additional Required Actions:

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 when there are reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident, the suspicion and the information upon which it is based is immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :



1. There is no evidence that an analysis of the suspected physical abuse of an identified resident was undertaken promptly after the licensee became aware of it. [s. 99. (a)]

2. The licensee's evaluation of its policy to promote zero tolerance of abuse and neglect of residents failed to identify what changes and improvements are required to prevent further occurrences.

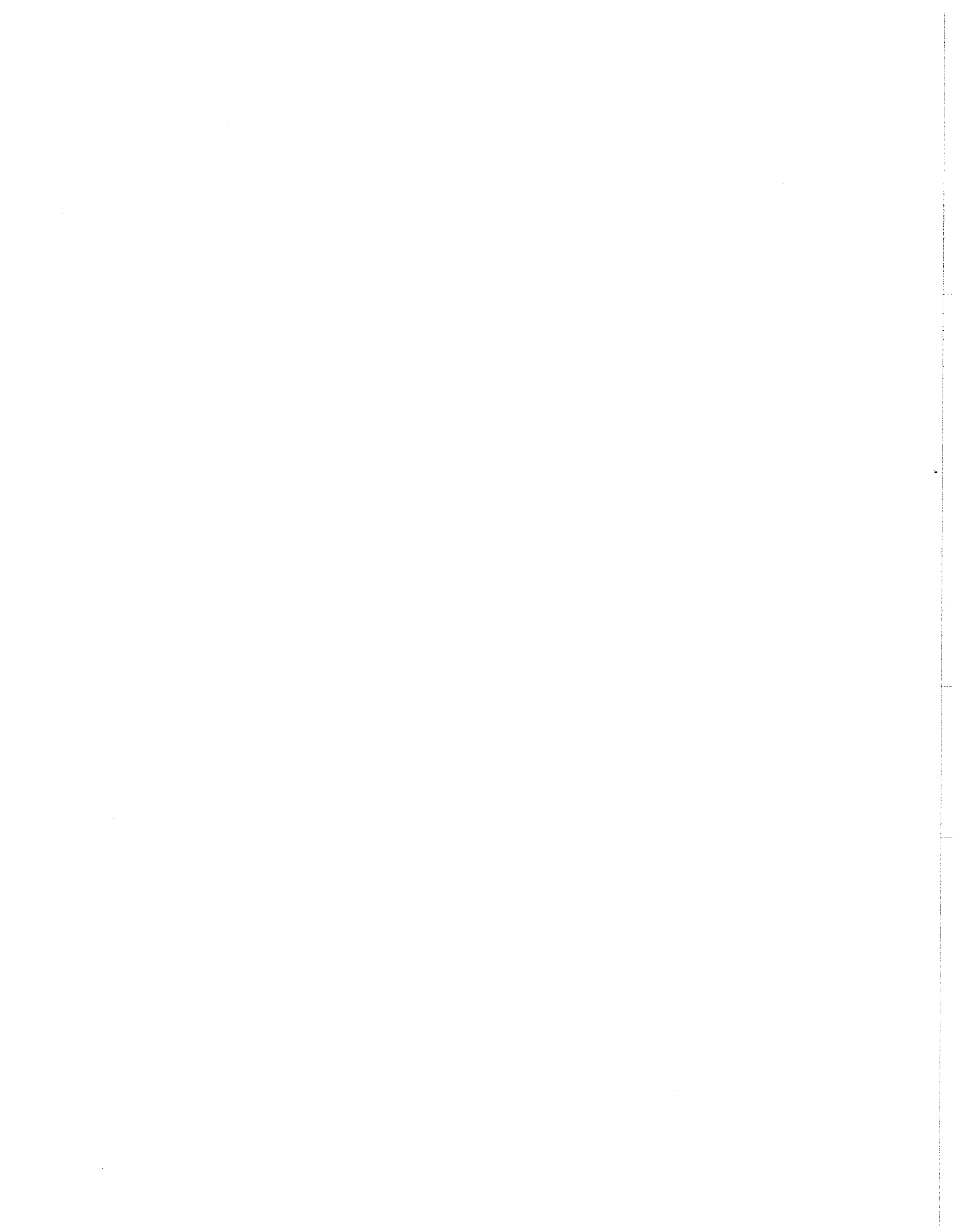
The "Quality Program Evaluation Resident Abuse" document provided to the inspector, indicates that an evaluation of the licensee's zero tolerance of abuse and neglect program was completed January 25, 2013 for the year 2012. The report indicates an increase in the number incidents of abuse from 8 in 2011 to 13 incidents in 2012.
The evaluation:
- fails to identify changes and improvements resulting from the annual evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents. The evaluation section entitled "List objectives with measurable outcomes for incidence of abuse for the coming year" is not completed.
- identifies that "objectives with the expected outcomes" were not met for the past year but fails to answer the subsequent question "if not, why not and what actions will be taken in the coming year" [s. 99. (b)]

3. The licensee's evaluation of its policy to promote zero tolerance of abuse and neglect of residents, dated January 25, 2013 failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home was considered in its program evaluation. [s. 99. (c)]

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 an analysis of every incident of suspected abuse is undertaken promptly after the licensee becomes aware of it, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints



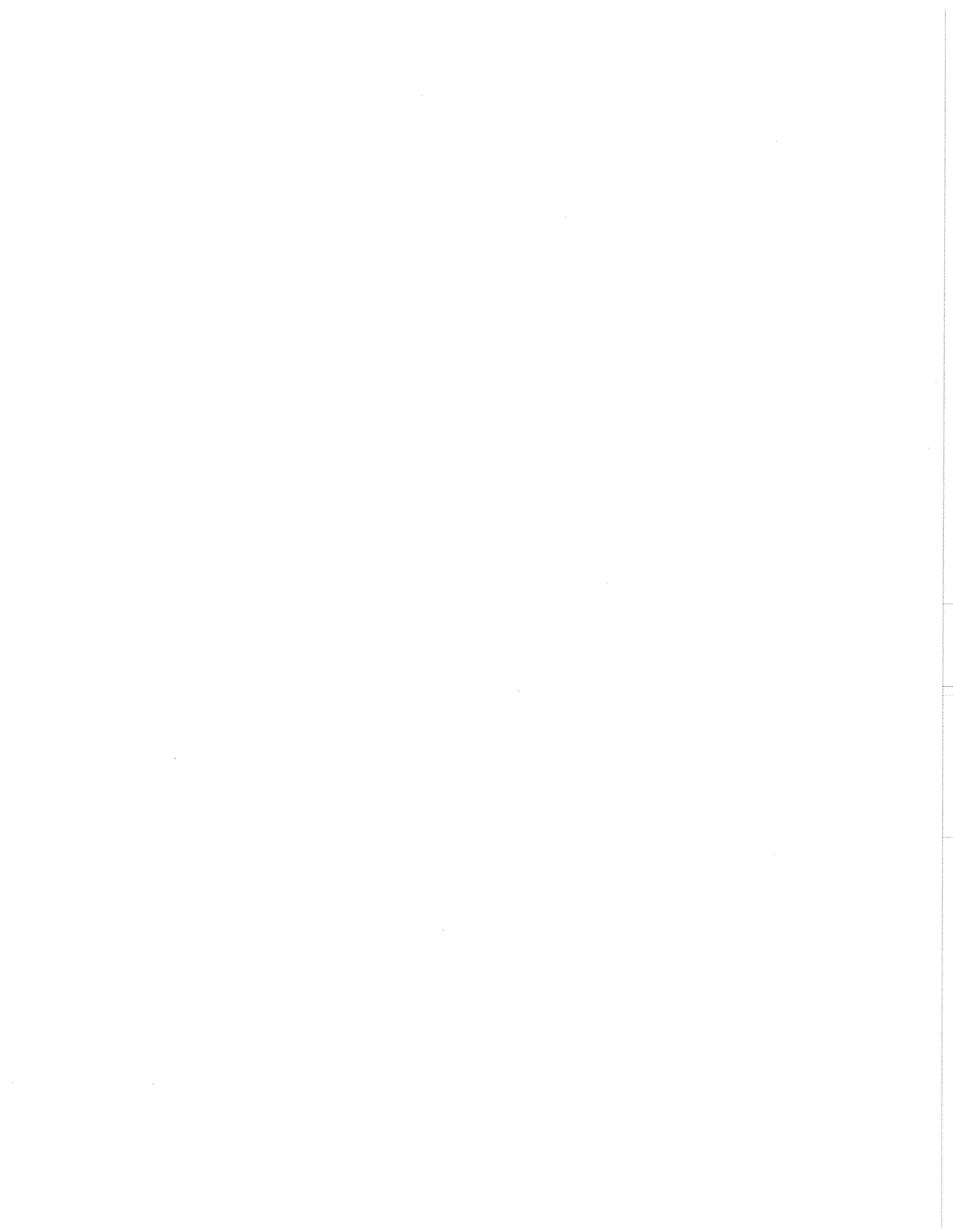
Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :



1. The licensee failed to ensure that a written complaint alleging harm or risk of harm to a resident was immediately investigated and a response provided within 10 business days of the receipt of the complaint.

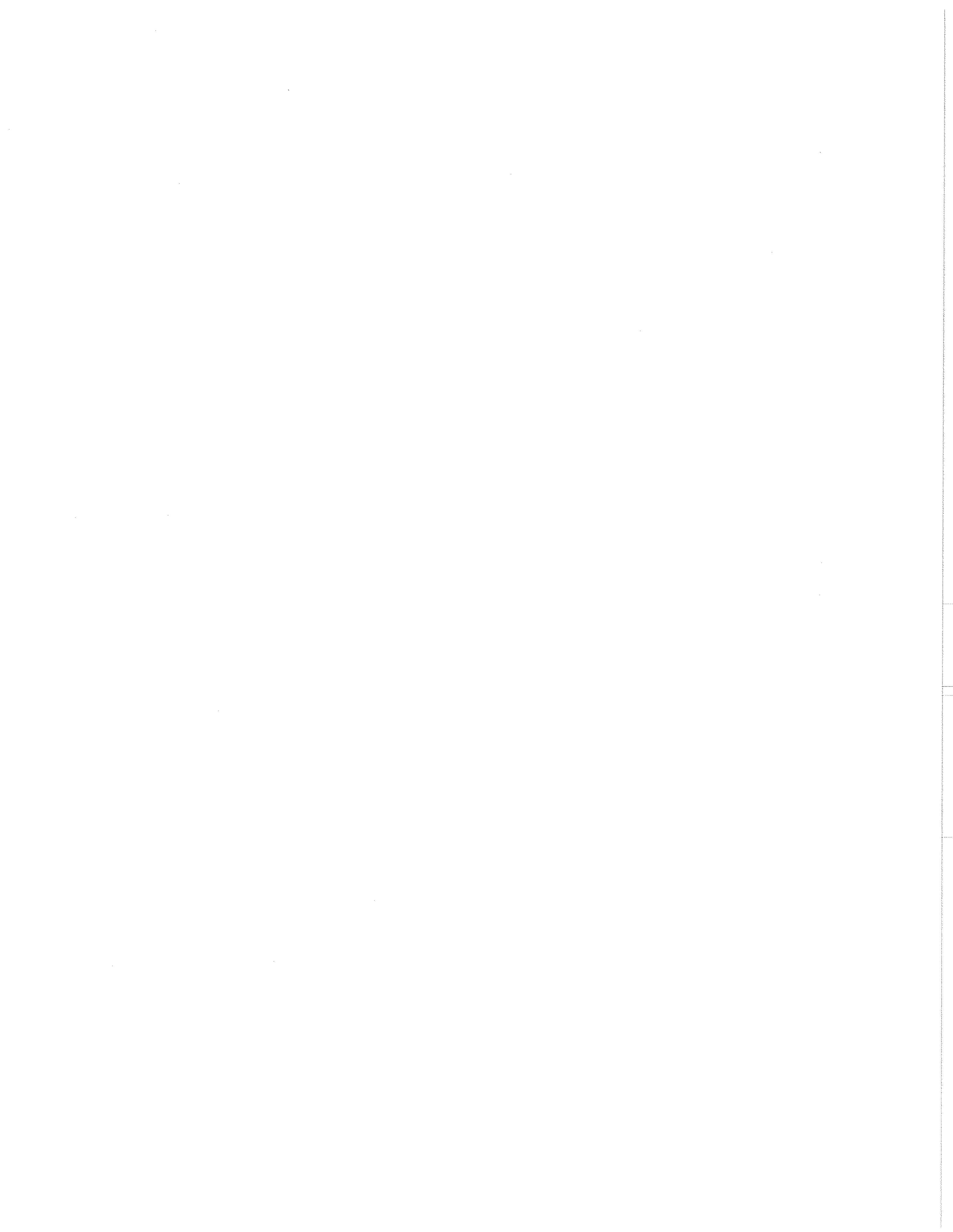
The Administrator received a written complaint expressing concerns about the care of an identified resident and injuries of an unknown origin.
Licensee records related to the complaint do not indicate that an investigation commenced or was completed. [s. 101. (1) 1.]

2. The licensee failed to provide a response to the person who made the complaint indicating what the licensee had done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

3. The licensee failed to maintain a documented record in the home of the action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and follow up action required, the final resolution, or the dates that any response was provided to the complainant. [s. 101. (2)]

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 all written and verbal complaints received by the home are investigated and resolved where possible within 10 days of the receipt of the complaint, that a response is made to the person who made the complaint and to ensure that a documented record of the complaint and action taken is maintained in the home, to be implemented voluntarily.



Issued on this 14th day of November, 2013

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

Pat Powers #157