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

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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
Jun 4, 2019	2019_603194_0013	019813-18, 025614-18, 030112-18, 030469-18, 030532-18, 008089-19	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 Rouge Valley
551 Conlins Road TORONTO ON M1B 5S1

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

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): May 22, 23, 24, 27, 28, 29, 30 and 31, 2019

The following was inspected Log #019813-18 and Log #025614-18 for resident to resident abuse. Log #030112-18, Log #008089-19, Log #030532-18 and Log #030469 -18 related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

Reviewed clinical health records of identified residents, home's internal investigation documentation, staff educational records, licensee's prevention of abuse policy and observed staff to resident provision of care.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", RC-02-01-02 dated April 2017 was complied with.

Review of the licensee's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02 dated April 2017 indicated;

Anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. The report may be made to the home and/or external authorities. At minimum, any individual who witnesses or suspect abuse or neglect or a resident must notify management immediately.

Log #019813-18:

During inspection of a Critical Incident Report (CIR) involving resident #002, Inspector #194 noted that the CIR described a resident to resident abuse situation that had not been reported.

Review of the CIR, progress notes and interview with PSW #115, RPN #116 and RN #117 was completed by Inspector #194.

The CIR indicated that on an identified date, PSW #115 witnessed resident #004 abuse resident #002 resulting in an injury.

During Interview with Inspector #194, PSW #115 confirmed witnessing the incident between resident #002 and resident #004 as documented in the CIR and Progress Notes.

During telephone interview with Inspector #194, RPN #116 indicated that the incident of abuse witnessed by PSW #115 on an identified date was reported to them but was not reported to RN #117.

During Interview with Inspector #194, RN #117 indicated that the incident of abuse involving resident #002 and #004 was not reported by RPN #116 at the time of the incident. RN #117 indicated that they had no knowledge of the incident between resident #002 and #004.

Administrator and DOC indicated that they were not part of the management team at the time of the incident and could not explain why the incident of resident to resident abuse

was not reported immediately to the Director.

The licensee failed to comply with "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy when RPN #116 did not immediately report and witness incident of resident to resident abuse to RN# 117. [s. 20. (1)]

2. . [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 by ensuring that staff comply with the Zero Tolerance of Resident Abuse and Neglect Policy, 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 has failed to ensure that the DOC, who had reasonable grounds to suspect that abuse occurred or may have occurred, immediately reported the suspicion

and the information upon which it was based to the Director.

Log #030469-18:

Inspector #194 reviewed the home internal investigation into the reported allegations of abuse by SDM of resident #001. The SDM of resident #001 reported that staff to resident abuse had occurred. The Director was not notified of the allegations of abuse, by the home until three days after the incident was reported.

During interview with Inspector #194, the Administrator indicated that the home did not notify the Director any earlier than the documented date recorded on the submitted CIR, which was three days after the initial allegations were received at the home.

Log #030532-18:

During inspection of a CIR for staff to resident abuse involving resident #003 on an identified date, Inspector #194, identified that the incident was not immediately reported to the Director. The CIR indicated that RPN #112 reported to RN #110 allegations of abuse by PSW #111 towards resident #003 on an identified date.

Review of the CIR, home's internal investigation and interviews with Administrator, ADOC #102 and RN #110 were completed by Inspector #194. The documentation reviewed and interviews completed indicated that the allegation abuse by PSW #111 towards resident #003 was provided by RN #110 to ADOC #102 on an identified date. The CIR was submitted to the Director one day after information was received by the ADOC #102.

During interview with Inspector #194, ADOC #102 indicated that RN #110 was late reporting of the allegations of abuse involving PSW #111 towards resident #003 and did not report the incident to the ADOC #102 until the following day.

Review of the internal investigation notes and CIR indicated that the ADOC #102 was informed of the allegations of abuse one day prior to submitting the CIR.

During interview with Inspector #194, RN #110 indicated that on an identified date, RPN #112 reported that they had witnessed allegations of abuse by PSW #111 towards resident #003. RN #110 indicated that they reported the allegations to ADOC #102 on the same day, after speaking to the staff involved.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported the information to the Director on two identified dates when allegations of abuse towards resident #001 and #003 were reported to the licensee. [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 of a resident resulting in harm or risk of harm will immediately report the information to the Director, to be implemented voluntarily.

WN #3: 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 safe transferring techniques were used by PSW #103 when assisting residents #001 on an identified date.

Log #030112-18:

During inspection of a CIR for allegations of staff to resident abuse involving resident #001, Inspector #194 received information from the home's internal investigation concluding that PSW #103 had completed an unsafe transfer of resident #001.

The plan of care indicated that resident #001 was assessed to be a two staff assist for transfers.

The progress notes reviewed for a specific period, related to transfer for resident #001 indicated the resident was unable to follow instructions and unable to participate in standing test by Physio staff, without physical support.

The home's internal abuse investigation included a statement from PSW #103. The statement indicated that on an identified date resident #001 had been transferred by PSW #103 without assistance from co-workers. PSW #103 further indicated that this was the first time they had transferred the resident #001 without assistance. The home's internal investigation indicated that there were no injuries to resident #001. PSW #103 was not available for interview at the time of the inspection.

During interview with Inspector #194, the Administrator indicated that PSW #103 was seen in evidence reviewed, completing a one staff assist transfer with resident #001 when resident was assessed to be a two staff transfer using a lifting device.

Log #008089-19:

During inspection of an allegation of staff to resident abuse reported in a CIR on an identified date it was noted by Inspector #194, that PSW #108 staff had transferred resident #002 using an unsafe technique, resulting in an injury.

Review of the home's internal investigation for allegations of staff to resident abuse involving resident #002 and a statement from PSW #108 was completed by Inspector #194. The home's internal investigation statement from PSW #108 indicated that resident #002 was transferred by PSW #108 independently when the plan of care indicated that the resident had been assessed for a two staff assist with a a lifting device. Resident #002 sustained an injury, after PSW #108 transferred the resident without assistance using a lifting device.

Review of the plan of care for resident #002 indicated that the resident had been assessed for a two staff assist with a lifting device as well as specific directions during transfer.

During interview with Inspector #194, the Administrator indicated that the allegations of staff to resident abuse were unfounded, but an unsafe transfer of the resident had been identified, during the home's internal abuse investigation.

The licensee failed to ensure that residents #001 and #002 were transferred using safe techniques by PSW #103 and #108 on two separate identified dates. [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 techniques when assisting residents, to be implemented voluntarily.

WN #4: 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. (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 has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Log #008089-19:

A CIR was submitted on an identified date, to report an allegation of staff to resident abuse involving resident #002. The CIR described that resident #002 was injured while care was being provided by PSW #108. The CIR was amended but the outcome of the licensee's internal abuse investigation were not provided to the Director.

During the interview the with Inspector #194, the Administrator indicated that the outcome of the licensee's internal abuse investigation was unfounded and should have been indicated in the amended CIR. [s. 23. (2)]

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Issued on this 21st day of June, 2019

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

Original report signed by the inspector.