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 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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2016	2016_417178_0017	028776-16, 030097-16	Complaint

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 STARWOOD
114 STARWOOD ROAD NEPEAN ON K2G 3N5

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

SUSAN LUI (178)

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 17, 18, 19, 2016. The complaint inspection concerned an allegation of staff to resident abuse.

This inspection included inspection of Critical Incident intake #027828-16, which concerned the same allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, The Director of Care (DOC), the Registered Dietitian (RD), the Dietary Manager, a registered practical nurse (RPN), personal support workers (PSWs), family members of residents.

During the course of the inspection the inspector also reviewed resident records, reviewed home records, and observed residents and resident care.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 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 the home's written policy to promote zero

tolerance of abuse and neglect of residents was complied with.

The inspector reviewed the home's policy Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, numbered RC-02-01-03, last updated April 2016. The policy states that in cases where the allegation of abuse and neglect is made against an employee, management will immediately advise the employee that they are being removed from the work schedule, with pay, pending investigation.

Interview with the home's DOC on October 18, 2016, revealed that on an identified date, the family member of resident #002 informed her that on an identified date the family observed a staff member handling resident #001 roughly while providing care. The DOC stated that she did not immediately remove the accused employee from work due to difficulties staffing the unit. The DOC ensured that the employee would not be working with resident #001, but did not remove the employee from work until several days later, allowing her to work on the same unit as resident #001, but not directly with resident #001.

During an interview on October 19, 2016, the DOC confirmed that she normally immediately puts any staff member accused of resident abuse off work, but confirmed that in this instance she did not comply with the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 20. (1)]

2. During an interview on October 18, 2016, the home's DOC confirmed that on an identified date, a family member of resident #002 informed her that the family had observed a staff member handling resident #001 roughly while providing care on an identified date. During an interview on October 19, 2016, the DOC confirmed that the Director under the LTCHA was first informed about the incident three days after the home was made aware of the incident.

The inspector reviewed the home's policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, numbered RC-02-01-02, last updated April 2016. The policy includes Appendix 1, titled Jurisdictional Reporting Requirements. The Appendix states that with regards to the requirement for Ontario, the Long-Term Care Homes Act (LTCHA) provides that any person who has reasonable grounds to suspect that abuse of a resident has occurred must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care.

During an interview on October 21, 2016, the DOC confirmed that it is the home's policy to immediately inform the Director under the LTCHA of abuse of a resident by anyone that resulted in harm or risk of harm. The DOC confirmed that the home's policy to promote zero tolerance of abuse and neglect was not complied with in this case because the allegation of abuse was not reported immediately. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported, was immediately investigated.

Review of an identified Critical Incident Report revealed that on an identified date, a family member of resident #002 reported to the DOC that on an identified date, the family had witnessed a staff member treating resident #001 roughly while providing care.

An October 18, 2016 interview with the home's DOC confirmed that on an identified date, the family member of resident #002 did inform her that on an identified date the family observed a staff member handling resident #001 roughly while providing care. During the interview on October 18, 2016, the DOC stated that an investigation into the allegation was not immediately initiated, as the home's senior management was out of town for a conference for the remainder of the week. During an interview on October 19, 2016, the DOC confirmed that the investigation into the incident commenced six days after the home became aware of the alleged incident. [s. 23. (1) (a)]

WN #3: 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 substitute decision maker (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 resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Review of an identified Critical Incident Report revealed that on an identified date, a family member of resident #002 reported to the DOC that on an identified date, the family had witnessed a staff member treating resident #001 roughly while providing care.

An October 18, 2016 interview with the home's DOC confirmed that on an identified date, the family member of resident #002 informed her that on an identified date, the family observed a staff member handling resident #001 roughly while providing care. During interview on October 18, 2016, the DOC stated that she did not immediately notify resident #001's substitute decision maker (SDM) that an allegation had been made that the resident had been treated roughly by a staff member. The DOC stated that resident #002's family told her they had already spoken to resident #001's SDM about the incident, so the DOC therefore did not notify resident #001's SDM herself. [s. 97. (1) (a)]

Issued on this 17th day of November, 2016

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

Original report signed by the inspector.