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

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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
Jul 18, 2018	2018_619550_0010	012804-18	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 Starwood
114 Starwood Road NEPEAN ON K2G 3N5

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

JOANNE HENRIE (550)

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): June 18, 26, 27, 28 and 29, 2018.

This Critical Incident inspection is related critical incident #2485-000021-18 the home submitted related to the allegations of abuse to a resident. Follow-up to to Compliance Order inspection #2018_619550_0011, log #006599-18 was conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), a Registered Nurse (RN), several Personal Support Worker (PSW), several residents and a family member.

In addition, the inspector reviewed resident health care records, a critical incident report, an investigation report from the licensee and the licensee's policy on abuse. The inspector observed resident care and services and staff and resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	WN	2018_593573_0006	550

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 specifically failed to ensure that their written zero tolerance of abuse and neglect of residents policy was complied with.

A critical incident report (CIR) was submitted to the Director on a specified date and time reporting an incident of suspected abuse of a resident by a staff member. It was reported that earlier that day, resident #001 reported to RN #102 that PSW #103 had hit them on a specific body part using a specific object and made a specified comment to the resident. It was also documented that the resident did not suffer any injuries and that the police were notified of the incident that same day.

Inspector #550 interviewed resident #001 on three different dates and times and the resident was not able to recall the incident.

During an interview, RN #102 told inspector #550 that on the date of the incident, at an approximate time, resident #001 reported to them that PSW #103 hit them on a specific body part with a specified object and made a specific comment. The RN believed this incident to be an incident of suspected staff to resident physical abuse. RN #102 told the inspector that they reported the incident to the DOC #100 approximately fifteen minutes after the incident was reported to them by the resident. RN #102 further indicated that they did not report this incident to the Director.

The Administrator #101 and DOC #100 informed the inspector that the incident was not immediately reported to the Director and to the police as they thought they had until the end of the working day to report. They left the home at a specific time to attend other duties and upon their return approximately 2.5hrs later, the DOC #100 continued the investigation and then reported the incident to the police 2hrs after they had returned to the home and to the Director by submitting a CIR report forty minutes later.

The Licensee's abuse policy titled "Zero Tolerance of Resident Abuse and Neglect:

Response and Reporting", policy #RC-02-01-02 was reviewed by the inspector. On page 1 of 5, the policy indicated:

Management will promptly and objectively report all incidents to external regulatory authorities, including the police if there are reasons to believe a criminal code offence has been committed.

Reporting on page 4 of 5 indicated the following:
Any employee or person who becomes aware of an alleged, suspected or witnessed 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. Note: In Ontario, in addition to the above, anyone who suspects or witnesses abuse, incompetent treatment of a resident, misappropriation of funds (resident or funds provided to the licensee under the LTCHA or the Local Health Systems Integration Act, and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line at 1-866-434-0144 and is protected by legislation (Whistleblower protection) from retaliation.

As evidenced, the licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy #RC-02-01-02 was not complied with as the Director and the police were not immediately notified of an incident of suspected staff to resident physical abuse. [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 written zero tolerance of abuse and neglect of residents policy is complied with, 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 specifically 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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

In accordance with O.Reg. 79/10, section 2, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

A critical incident report (CIR) was submitted to the Director on a specific date at a specific time reporting an incident of abuse to a resident by a staff member. It was reported that on this date at a specified time, resident #001 reported to RN #102 that PSW #103 hit them on a specific body part with a specified object and made a comment to the resident.

A review of the progress notes in the resident's health care records and an interview with RN #102 revealed that the incident was reported at a specific time, 7.25hrs earlier than indicated on the report.

During an interview, RN #102 told inspector #550 that on that day at a specified time, they responded to a wireless alarm in resident #001's room. When the RN entered the

resident's room, the resident was sitting on the side of the bed and told the RN they wanted to get up. The RN informed the resident that PSW #103 would be coming soon to assist them and resident #001 responded by telling them that this PSW had already came and hit them on a specific body part with a specified object and had made a comment. RN #102 told the inspector that the resident did not have any injuries from this incident. The RN reported the incident to the DOC #100 approximately fifteen minutes later.

The DOC confirmed to inspector #550 during an interview that the incident occurred at a specific time and not at the time indicated on the CIR. DOC #100 said that at the time the incident was reported to them, they believed the incident to be an incident of physical abuse. The DOC #100 told the inspector that it must have been approximately 1.25hrs after the incident was reported to the RN when they were made aware of the incident. The Administrator #101 and DOC #100 informed the inspector that the incident was not immediately reported to the Director and to the police as they thought they had until the end of the working day to report. They left the home at a specific time to attend other duties and upon their return approximately 2.5hrs later, the DOC #100 continued the investigation and then reported the incident to the police 2hrs after they had returned to the home and to the Director by submitting a CIR report forty minutes later.

This incident of staff to resident alleged abuse was not immediately reported 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 any person who had reasonable grounds to suspect that 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, to be implemented voluntarily.

WN #3: 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 failed to ensure 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.

A critical incident report (CIR) was submitted to the Director on a specific date at a specific time reporting an incident of abuse to a resident by a staff member. It was reported that on this date at a specified time, resident #001 reported to RN #102 that PSW #103 hit them on a specific body part with a specified object and made a comment to the resident.

During an interview, RN #102 told inspector #550 that on that day at a specified time, they responded to a wireless alarm in resident #001's room. When the RN entered the resident's room, the resident was sitting on the side of the bed and told the RN they wanted to get up. The RN informed the resident that PSW #103 would be coming soon to assist them and resident #001 responded by telling them that this PSW had already came and hit them on a specific body part with a specified object and had made a comment. RN #102 told the inspector that the resident did not have any injuries from this incident. The RN reported the incident to the DOC #100 approximately fifteen minutes later.

The DOC #100 told inspector #550 during an interview that RN #102 informed them on a specific date and time, resident #001 had reported to them having been hit on a specific body part with a specified object by PSW #103. The Administrator #101 and the DOC #100 informed the inspector the police were not immediately notified of the incident as they thought they had until the end of the business day to report. They left the home at a specific time to attend other duties and upon their return approximately 2.5hrs later, the DOC #100 continued the investigation and then reported the incident to the police 2hrs after they had returned to the home

This incident of staff to resident alleged abuse was not immediately reported to the police. [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 to ensure that the police 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, to be implemented voluntarily.

Issued on this 3rd day of August, 2018

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

Original report signed by the inspector.