Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

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| Report Issue Date: October 28, 2024 |
| Inspection Number: 2024-1078-0002 |
| Inspection Type:<br>Critical Incident |
| Licensee: Extendicare (Canada) Inc. |
| Long Term Care Home and City: Extendicare Starwood, Nepean |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15, 16, 17, 18, 21, 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00125359-CIR-2485-000013-24-Alleged resident to resident sexual abuse.
- Intake: #00126596-CIR-2485-000014-24-Alleged staff to resident physical abuse.
- Intake: #00126783-CIR-2485-000015-24-Alleged staff to resident physical abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Police Notification

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service 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. 246 / 22, s. 105, 390 (2).

The licensee has failed to immediately notify the police of an alleged incident of physical abuse of a resident by a Personal Support Worker (PSW).

Sources: Resident's medical records, Critical Incident Report, the home's investigation file and an interview with the Director of Care (DOC).

The licensee has failed to immediately notify the police of a witnessed incident of physical abuse of a resident by a PSW.

Sources: Resident's medical records, the home's investigation file and an interview with the DOC.

## COMPLIANCE ORDER CO #001 Duty to Protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A. Provide training to a Personal Support Worker (PSW) and a Registered Nurse (RN) on physical abuse as per legislative definition as the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident and actions to be taken, such as immediate interventions to protect residents when information is known that meets the definition, and;

B. A written record of this training shall include a copy of the training provided for the PSW and the RN, the date and time of the training, the name of the person who provided the training and must be kept for the requirements under step A. of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to protect a resident from physical abuse by a Personal Support Worker (PSW).

Rationale and Summary:

Critical Incident Report reported that a PSW witnessed another PSW hitting a resident on a specified date in September 2024.

Progress note by a Registered Nurse (RN) indicated that it had been reported by a PSW that another PSW hit a resident. The RN documented that they reported this incident to the Manager on Call and that they were going to complete a skin assessment.

Risk Management-Responsive Behaviour-Physical Aggression-Recipient form completed by an RN indicated that a PSW had reported that they had observed another PSW hit a resident.

Home's investigation file indicated that a PSW witnessed the incident of staff to resident physical abuse of a resident by another PSW and was reported to an RN and the Manager on Call.

Zero Tolerance of Resident Abuse and Neglect policy last reviewed November 2023 indicated 'All homes will implement a comprehensive zero tolerance of resident abuse and neglect program including measure to: prevent, detect and immediately respond to any alleged incident of resident abuse or neglect. Immediately respond to any form of alleged, potential, suspected or witnessed abuse (physical, verbal, emotional, sexual, financial and neglect). Intervene if safe to do so. If necessary, to maintain safety and security of any individual of the home, call a CODE WHITE or contact police immediately if resident in danger.'

The Director of Care (DOC) stated that they were informed by the Manager on Call that they had received a call from an RN stating that a PSW had witnessed another PSW physically hitting a resident.. The DOC stated that the Manger on Call had told the RN to have the PSW stop care but stay in the home until they arrived.

A PSW stated that they had witnessed another PSW hitting a resident. The PSW stated that they did not intervene between the PSW and the resident but that they immediately reported this incident to an RN. The PSW stated that they did not return to the resident's room at that time as the RN had asked them to make a written statement of what they had witnessed. The PSW stated that they had been trained on the home's zero tolerance of resident abuse and neglect policy.

An RN stated that it was reported by a PSW that they had witnessed another PSW hitting a resident. The RN stated that the PSW did not enter the room but was in the doorway and witnessed another PSW hitting a resident. The RN stated that then they called the Manager on Call who directed them to complete a skin assessment on the resident and to inform the PSW to wait at the home for the Manager on Call to arrive. The RN stated that they spoke with the PSW to instruct them to wait for the Manager on Call to arrive and that the PSW continued with their PSW duties on the unit until the end of their shift. The RN stated that they had been trained on the home's zero tolerance of resident abuse and neglect policy.

Impact and Risk:

By the PSW not intervening immediately upon witnessing the incident of physical abuse of a resident by another PSW and by the RN not intervening immediately upon being informed of this incident and by the PSW continuing to perform their PSW duties on the unit after this incident occurred placed a resident and other residents at high risk of abuse.

Sources: Resident's medical records, Critical Incident Report, Risk Management report, Zero Tolerance of Resident Abuse and Neglect Policy, home's investigation file and interviews with the DOC, an RN and a PSW.

This order must be complied with by December 6, 2024

## REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.