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
Sep 13, 2018	2018_563670_0019	021064-18	Complaint

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 Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

DEBRA CHURCHER (670)

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): September 4, 5, 6, 7 and 10, 2018.

The following intakes were completed within this inspection:
Log# 021064-18 Info Line #58987-LO related to a complaint alleging staff to resident abuse.
Log# 021644-18 Critical Incident System Report #2904-000024-18 related to alleged staff to resident abuse.
Inspector Cassandra Taylor #725 was present for this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), one Registered Practical Nurse (RPN), five Personal Support Workers (PSW), families and residents.

The inspector(s) also observed resident and staff interactions, observed resident rooms and common areas, observed provision of care, reviewed health care records and plans of care for identified residents, reviewed policies and procedures, reviewed the home's investigation notes, reviewed contracted agency education and reviewed audio and video files.

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.
- **5 WN(s)**
- **4 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Ontario Regulation 79/10, s. 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, "any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Ontario Regulation 79/10, s. 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The Ministry of Health and Long-Term Care received a Critical Incident System report (CIS) #2904-000024-18 on a specific date with a specific occurrence date. The CIS stated that resident #001's family member had contacted the home on a specific date, regarding specific concerns they had while reviewing the audio and video from resident #001's room from a specific date. The Ministry of Health and Long-Term Care also received a complaint on a specific date, Info Line-58987-LO, from resident #001's family member related specific concerns. The complainant also provided the Ministry of Health and Long-Term Care with an audio video file from a specific date.

On a specific date, review of audio video recording short version was conducted by Inspector #670 and Inspector #725. Inspectors were able to review care provided and verbal interactions between resident #001, PSW #106 and PSW #107 throughout the review. During this video the resident was visibly and audibly upset.

The home's policy titled Zero Tolerance of Resident Abuse and Neglect Program, RC-02-01-01, updated April 2017, stated Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated.

During an interview on a specific date, Administrator #105 stated that the home became aware of the allegations on a specific date, and immediately removed the staff members from the schedule pending investigation. The home completed an internal investigation and found that the allegations to be factual and both staff members were subsequently terminated.

The licensee has failed to ensure that residents were protected from abuse by anyone.

[s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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 staff use safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long-Term Care received a complaint on a specific date, Info Line-58987-LO, related to concerns regarding the treatment of resident #001. The complainant also provided the Ministry of Health and Long-Term Care with an audio video file from a specific date.

Review of the audio video file was completed on a specific date. At two specific time into the video resident #001 was transferred with a specific device and was taken into the bathroom and lowered onto the toilet. Personal Support Workers (PSW) #106 and #107 were present. PSW #107 stated that they were going on break and would be back. Both PSW's left the room. The specific device appeared to still be attached. The resident remained on the toilet, alone, for a total of 17 minutes and 53 seconds.

During an interview with PSW #106 on a specific date, PSW #106 stated that on a specific date, they had used a specific device to put resident #001 on the toilet, locked the wheels and turned the power off to the specific device and left resident #001 on the toilet. PSW #106 shared that resident #001 remained attached to the device when left on the toilet alone. PSW #106 stated that when they returned to the room the resident had unhooked on side of the specific device themselves.

The home's policy titled Safe Lifting with Care Program, LP-01-01-01, last updated August 2017, under the procedure steps applicable to all types of mechanical lifts, stated #15 Two people are required at all times. Under the procedure steps specifically for the sit to stand lift the policy stated, #16 e. Remain with resident during the entire time the sling is connected to the mechanical lift.

During an interview with Director of Care (DOC) #104 on a specific date, they acknowledged that resident #001 was left attached to a specific device, while left alone on the toilet on a specific date. DOC #104 stated that it would be the expectation of the home that two staff members would be with the resident when attached to the specific device.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [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 ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: The Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports,

and the protections afforded by section 26. 6.

The Long-Term Care Homes Act, 2007 defines staff as, "Persons who work at the home, pursuant to a contract or agreement with the licensee."

During an interview with Personal Support Worker (PSW) #102 on a specific date, they identified themselves as a PSW that worked for an agency that was contracted by the long term care home to provide one to one staffing for specific residents. The PSW identified the agency as Home Instead. When PSW #102 was asked if they had received training regarding the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports and whistleblowing protection, the PSW stated that Home instead provided education during orientation.

Review of the Home Instead 2018 Caregiver Handbook had a section titled "Client Rights" that listed the following;
-To be treated with respect and dignity.
-To privacy and confidentiality.
-To involve and advocate of their choice.
-To information that is accessible, accurate, timely and understandable.
-To be consulted about needs and preferences, and be involved in decision making.
-To express grievances and have them dealt with fairly.
-To have cultural needs respected.
-To have one's needs met in a professional and ethical manner.
-To give or hold consent to services and/or programs.
-To withdraw services at any time.
-To regular reviews of service provision to ensure care remains appropriate.
-T receive an efficient and effective service, delivered in a timely manner.

The Long-Term Care Homes Act, 2007 Resident Bill of Rights is as follows;
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Further review of the Home Instead 2018 Caregiver Handbook showed a section titled "Reporting Abuse Regarding Client/Family Member" that stated as follows; Complaints of violence or inappropriate behavior will be reported immediately to the Supervisor. Complaints can be made in person, through e-mail or by telephone. When complaints are brought forward it is imperative that all parties involved maintain confidentiality in an attempt to protect the privacy of all individuals. However, confidentiality may be compromised in cases where it is perceived that imminent danger exists or in cases where it is required by law. In the event that an emergency or any potentially high risk

situation occurs outside of business hours contact the on-call person or contact the local police by dialing 911. Failure to report workplace violence or harassment will result in immediate termination.

During an interview with Administrator #105 on a specific date, the Home Instead education was reviewed. Administrator #105 stated that agency staff do not review the home's policy and are not educated by the facility, and that Home Instead provides the education prior to the staff member coming to the facility. Administrator #105 shared that they had previously reviewed the Home Instead education and was comfortable with the education as they only use agency staff for one to one staffing. Administrator #105 acknowledged that the education provided by Home Instead does not educate staff on the Long Term Care Home Residents' Bill of Rights, the home's prevention of abuse and neglect policy or any duties to report or protections.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: The Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26. 6. [s. 76. (2) 3.]

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 no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: The Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26. 6, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member; The results of the staff member's criminal reference check under subsection 75 (2) of the Act.

The Long-Term Care Homes Act, 2007 defines staff as, "Persons who work at the home, pursuant to a contract or agreement with the licensee."

During an interview with Personal Support Worker (PSW) #102 on a specific date, they identified themselves as a PSW that worked for an agency that was contracted by the long term care home to provide one to one staffing for specific residents.

Review of the home's documentation for PSW #102 showed one document that contained demographic information, a workplace orientation checklist and a worker acknowledgment stating that they had received the orientation listed on the checklist and understood their obligations to work in compliance with the company's health and safety program and policies and procedures.

During an interview on a specific date, Administrator #105 stated that they do not keep any files on agency staff and that the agency ensures that the staff member has a criminal reference check. Administrator #105 stated that they had never gotten a criminal reference check for any agency staff as it is part of the agreement with the agency.

The licensee has failed to ensure records of criminal reference checks for agency staff were kept by the home as per legislative requirements. [s. 234. (1) 3.]

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 that a record is kept for each staff member of the home that includes at least the following with respect to the staff member: 3) Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act., to be implemented voluntarily.

WN #5: 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 any 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: 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.

The Ministry of Health and Long-Term Care received a Critical Incident System report (CIS) #2904-000024-18 on a specific date, with an occurrence date of two days prior to the date the CIS was submitted. The CIS stated that resident #001's family member had contacted the home one day after the occurrence date listed on the CIS, regarding concerns they had while reviewing the audio and video from resident #001's room from the occurrence date listed on the CIS.

The home's policy titled, Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, RC-02-01-03, last updated April 2017, under the procedure section, stated 1. The administrator or designate will oversee the completion of all steps required by the policy and procedures, in order to manage the case to resolution. This includes: c. Ensuring that reporting requirements to provincial/regulatory bodies have been completed as required; d. Ensuring that disclosure of all information pertinent to the incident is made within prescribed timelines and to the appropriate individuals, in compliance with privacy policies and legislation and all provincial regulatory body requirements.

An interview was conducted with Administrator #105 who stated that the home became aware of the allegation on a specific date which would have been the day after the occurrence, and immediately started an investigation and that there were three staff members working on the CIS and they were unable to submit. Administrator #105 acknowledged that they did suspect that there had been a specific, reportable occurrence, once they received the allegation the day after the occurrence, and also acknowledged that they were aware of the availability of the action line for reporting when a CIS cannot be submitted for any reason.

The licensee has failed to ensure that any 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: 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. [s. 24. (1)]

Issued on this 13th day of September, 2018

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

Original report signed by the inspector.