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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2016	2016_290551_0001	009293-14, 009301-14, 009453-14, 009479-14, 002792-15, 014550-15	Critical Incident System

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 WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

MEGAN MACPHAIL (551)

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): January 13, 14, 15, 20, 21 and 22, 2016.

The following Critical Incident Reports were inspected: 009293-14 (alleged resident to resident abuse), 009301-14 (alleged resident to resident abuse), 009453-14 (alleged staff to resident abuse), 009479-14 (alleged resident to resident abuse), 002792-15 (alleged resident to resident abuse) and 014550-15 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, Activities Staff Members, the Social Worker, the Assistant Director of Care, the Director of Care and the Administrator.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 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 suspected abuse was immediately reported to the Director.

On a specified day in February 2015, Resident #004 reported to a staff member that he/she had been spoken to inappropriately, in a sexual nature, by Resident #002, and that he/she had attempted to touch him/her inappropriately but had not succeeded. The resident reported that the incident had occurred a few days earlier.

The home began an immediate investigation. The Director was not notified of the suspected abuse until two days later.

[002792-15] [s. 24. (1)]

WN #2: 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 Resident #011's SDM was notified within 12 hours upon becoming aware of any other alleged incident of abuse or neglect of the resident.

On a specified day in November 2014, Resident #010 brought forward an allegation of staff to resident abuse involving Resident #011. Resident #010 alleged that Resident #011 had been treated roughly by a PSW during the provision of Resident #011's care.

The home began an immediate investigation and concluded, on the same day, that Resident #011 had not been abused.

In an interview with the Administrator, she stated that the SDM is always notified when there is an allegation of abuse, and if there is no documentation in the progress notes indicating that the SDM was contacted, it can be assumed that the SDM was not.

Resident #011's health care record was reviewed, and there is no indication that the SDM was notified of the incident of alleged abuse.

In the Critical Incident Report (CIR), it states that the SDM was not contacted because on becoming aware of the allegation, an investigative meeting was immediately held with the PSW in question, and it was determined that the abuse had not occurred.

[009453-14] [s. 97. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse.

On a specified day in October 2014, Resident #007 slapped Resident #006 on both sides of his/her face.

The Long-Term Care Home Emergency Pager (after hours) was contacted on the same day of the incident to notify of the suspected abuse.

The Administrator indicated that the home's practice at the time was to notify the Director of any suspected abuse through the after hours pager. The home would then submit a CIR if their investigation concluded that actual abuse had occurred or would notify the Central Intake Assessment and Triage Team (CIATT) via email that a CIR was not required.

The home did not follow-up to the after hours page on the specified day October 2014 and did not send the report to the Director until December 8, 2014 at the request of CIATT. The home had not emailed CIATT to notify that their investigation had concluded that the incident did not have to be reported to the Director.

The Administrator stated that the home is now following the Ministry of Health and Long-Term Care Decision Tree for reporting suspected abuse to the Director.

[009203-14] [s. 104. (2)]

2. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

On a specific day in November 2014, Resident #010 brought forward an allegation of staff to resident abuse involving a staff member and Resident #011.

The home began an immediate investigation and notified the Central Intake Assessment and Triage Team (CIATT) of the allegation of abuse via email on the same day as the incident.

Two weeks after the incident, the Administrator sent a follow-up email to CIATT stating that the home's investigation had concluded that abuse had not occurred therefore a CIR would not be submitted. This report was not made to the Director within 10 days.

[009453-14] [s. 104. (2)]

3. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

On a specified day in November 2014, Resident #009 was struck in the face by Resident #008. The home suspected that this incident constituted abuse and began an immediate investigation.

The Long-Term Care Home Emergency Pager (after hours) was contacted on the same day of the incident to notify of the suspected abuse.

The Administrator indicated that the home's practice at the time was to notify the Director of any suspected abuse through the after hours pager. The home would then submit a CIR if their investigation concluded that actual abuse had occurred or would notify the Central Intake Assessment and Triage Team (CIATT) via email that a CIR was not required.

The home did not follow-up to the after hours page on the specified day in November 2014 and did not send the report to the Director until December 8, 2014 at the request of CIATT. The home had not emailed CIATT to notify that their investigation had concluded

that the incident did not have to be reported to the Director.

The Administrator stated that the home is now following the Ministry of Health and Long-Term Care Decision Tree for reporting suspected abuse to the Director.

[009301-14] [s. 104. (2)]

Issued on this 12th day of February, 2016

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

Original report signed by the inspector.