Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 12, 2020	2020_809733_0006	002111-20, 004303-20, 011260-20, 013091-20	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 West End Villa
2179 Elmira Drive OTTAWA ON K2C 3S1

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

MARK MCGILL (733), SUSAN LUI (178)

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): July 8, 9,10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 28, 29, 2020

The following logs were completed during this inspection:
Log 013091-20 is related to an unexpected death of a resident.
Log 004303-20 is related to alleged abuse and responsive behaviour.
Log 011260-20 is related to a fall.
Log 002111-20 is related to responsive behaviour.

During the course of the inspection, the inspector(s) spoke with Clinical Coordinator, Personal Support Workers, Registered Dietitian, Nurses, Director of Care.
The inspector also spoke to residents and observed residents and resident care.
Resident health records, Abuse prevention policy, training records were also reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting indicated that 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. The policy also indicated that staff must complete an internal incident report.

A Critical Incident Report (CIR) was submitted by the licensee.The CIR indicated that an RPN observed resident #003 sitting on the bed of resident #002 close to resident #002, who was lying on the bed. The RPN observed resident #002 touching resident #003 inappropriately. The RPN requested that resident #002 leave the room and the resident did so.

The RPN indicated to inspector #178 that they witnessed resident #003 sitting on resident #002's bed while resident #002 was lying in the bed. They indicated that they witnessed resident #002's hand go close to resident #003, attempting to touch them inappropriately. They also indicated that they considered this act sexual abuse because resident #003 is cognitively impaired. They indicated that they immediately asked resident #003 to leave the room, told the staff to keep the residents apart, charted the incident in the progress notes, but did not inform the charge nurse. They indicated that the following morning, Clinical Coordinator #109 saw the progress note and spoke to the RPN about the incident, along with Clinical Coordinator #100 and the Director of Care (DOC). The RPN indicated that they were advised that they should have notified the RN in charge and contacted the Manager on call after witnessing the incident.

The DOC indicated to Inspector #178 that the RPN should have immediately reported the incident between resident #002 and resident #003 to the RN in charge, who would have contacted the Manager on call, and then reported the incident to the Ministry of Long-Term Care via the After Hours Line. The DOC also indicated that they were unable to find an internal incident report documenting this incident.

As such, the licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, specifically with regards to reporting and documenting a suspected incident of sexual abuse. [s. 20. (1)]

Issued on this 31st day of August, 2020

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

Original report signed by the inspector.