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 # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2017	2017_565612_0004	012324-16, 024558-16, 024827-16, 025212-16, 025805-16, 028273-16, 028491-16, 029639-16, 030222-16, 030301-16, 031243-16, 031391-16, 031675-16, 031773-16, 031788-16, 031896-16, 032403-16, 032504-16, 032878-16, 033059-16, 033076-16, 033705-16, 034162-16, 035085-16, 035286-16	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 YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

SARAH CHARETTE (612), ALAIN PLANTE (620), JENNIFER LAURICELLA (542)

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 23-27, 2017.

The following Critical Incidents (CIs) were inspected during this inspection:
- Nine logs the home submitted related to resident to resident abuse,
- Eight logs the home submitted related to staff to resident abuse,
- Three logs the home submitted related to an unexpected death, and
- Five logs related to residents who experienced a fall.

A Follow Up Inspection #2017_565612_0002 and Complaint Inspection #2017_565612_0003 were conducted concurrently to this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Manager, Rehabilitation Assistant, Resident Program Manager, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed resident care areas, observed the provision of care towards residents, observed staff to resident and resident to resident interactions, reviewed investigation notes, staff personnel files and residents' health care records.

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.
5 WN(s)
3 VPC(s)
1 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 and free from neglect by the licensee or staff in the home.

A Critical Incident (CI) report was submitted to the Director on a specific date in November, 2016, regarding staff to resident physical abuse. The CI report indicated that resident #020 had reported to their family member that they were provided with rough care and felt bullied and afraid of PSW #106. Resident #020's family member reported this information to the home on the same date the CI report was submitted to the Director.

On January 24, 2017, Inspector #542 reviewed the home's investigation files regarding the above CI report along with PSW #106's employee file. The home placed PSW #106 on a paid leave on the same date the CI report was submitted to the Director, until the investigation was completed. The home's investigation revealed that witnesses described PSW #106's approach to be aggressive, rushed and disrespectful. A letter was located on PSW #106's employee file where they were provided with disciplinary action due to the above incident.

Upon review of PSW #106's employee file and the home's investigation file regarding the above CI report, Inspector #542 located the following:

1. A letter of concern dated five days prior to the CI report submitted to the Director from RPN #122, indicated that PSW #106 had provided resident #039 with improper personal care and verbally abused a resident. It was also documented in the letter that residents were not happy with PSW #106.

2. Investigation notes dated four days prior to the CI report submitted to the Director, indicated that the home spoke to resident #012 as they had concerns about PSW #106. Resident #012 had described physical actions of PSW #106 towards them. Resident #012 indicated that they did not want PSW #106 to care for them anymore.

3. A letter of concern dated the same date that the CI report was submitted from RPN #122, addressed to ADOC #102, indicated that while PSW #106 was providing care to resident #039, RPN #122 overheard resident #039 telling PSW #106 that they don't have to be so rough.

A) On January 25, 2017, Inspector #542 interviewed the DOC regarding the three allegations mentioned above regarding PSW #106. The DOC indicated that because the home had received the other letters around the same time as the submission of the CI report regarding resident #020, that they combined the other allegations in with the CI report. Inspector #542 reviewed the CI report and noted that it did not contain any residents, other than resident #020, furthermore there was no description of the three other allegations.

Inspector #542 interviewed ADOC #102 regarding the three allegations mentioned above and they verified that the home did not immediately inform the Director of the allegations of abuse.

On January 25, 2017, Inspector #542 interviewed the Administrator regarding the letter dated five days prior to the CI report submitted to the Director, and they confirmed that the information was not reported to the Director.

According to the LTCHA, 2007, s. 24, 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: 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. Please refer to WN # 4.

B) Inspector #542 reviewed the investigation notes provided by the home related to PSW #106. The Inspector was unable to locate the following:
- Any investigation notes related to the alleged verbal abuse of an unidentified resident
- Any investigation notes related to the concerns that resident #012 made regarding the physical actions of PSW #106 and not wanting PSW #106 to provide care for them anymore.
- Any investigation notes related to the letter of concern which alleged that resident #039 had told PSW #106 that they were too rough.

On January 27, 2017, Inspector #542 interviewed PSW #106 and asked them about the verbal abuse of an unidentified resident. PSW #106 indicated that the home did not speak to them about the alleged incident.

On January 26, 2017, Inspector #542 interviewed the Administrator regarding the alleged verbal abuse of a resident. The Administrator stated that the home did not further investigate the alleged incident when it was brought forward and that the home failed to

complete a thorough investigation. The Administrator also stated that the home did not further investigate the letter of concern which alleged that a staff member overheard resident #039 say to PSW #106 that they were too rough.

Inspector #542 interviewed ADOC #102 regarding the alleged incidents. The ADOC stated that they did not complete their investigation regarding the alleged verbal abuse of an unidentified resident. They indicated that they did not speak with PSW #106 regarding the allegation that resident #039 said PSW #106 provided rough care; however, they had attempted to speak with resident #039. They were unable to provide any investigation documents.

In an interview with RPN #122 on January 26, 2017, they stated that the home did not speak to them regarding the concerns they had brought forward including the alleged verbal abuse of an unidentified resident and when they overheard resident #039 saying that PSW #106 was too rough when providing care. RPN #122 informed the Inspector #543 that they had also reported the second concern to RN #129 and they instructed RPN #122 to document it.

According to the LTCHA, 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone. See WN #3 for further details. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 homes policy that promotes zero tolerance of abuse and neglect was complied with.

Inspector #612 reviewed a CI report submitted to the Director on a specific date in October, 2016. The report indicated that a student on placement (#111) was interviewing residents as part of the resident's satisfaction surveys. During an interview, resident #034 stated that resident #019 had reported to them that PSW #105 had treated them like a baby. The concern was relayed to the Volunteer Manager who then relayed the information to ADOC #102.

Inspector #612 reviewed the home's internal investigation notes which stated that ADOC #102 met with resident #019 the same day they received the report. They stated that when PSW #105 provided them with specific care, it made them feel uncomfortable. Resident #019 stated that during the care they told PSW #105 that they needed more training, that they were unprofessional. The home launched an investigation, placed PSW #105 on leave, resident #019's family was notified and the police were notified. Resident #019 was discharged from the home not long after.

The investigation notes revealed that PSW #105 was interviewed the day after the information was reported to the home. PSW #105 denied ever providing the specific care to the resident, and that they had never provided care to the resident alone. They stated that they had always provided care with PSW #132. When the home had interviewed PSW #132, they stated that they had assisted PSW #105 with a portion of resident #019's care and that PSW #105 had assisted resident #019 with the specific care. The home reviewed documentation in point click care (PCC) and noted that PSW #105 had documented that they had provided resident #019 the specific care.

The home's investigation notes revealed that PSW #105's employment was terminated as a result of "serious misconduct".

The Inspector reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect", last updated April 2016, which stated that any form of abuse by any person interacting with residents, whether through deliberate acts or negligence, would not be tolerated. The policy also stated that the home was committed to providing a safe and secure environment in which all residents were treated with dignity and respect.

On January 26, 2017, Inspector #612 interviewed the Administrator and ADOC #102 who confirmed that PSW #105's employment was terminated. The Administrator stated that resident #019 was discharged from them home and as a result they were not aware of the outcome of the police investigation. The Administrator reported that they were very concerned about the allegation and during the investigation PSW #105's story was not consistent with documentation and the staff interviews. [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 homes policy that promotes zero tolerance of abuse and neglect was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated: abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

A CI report was submitted to the Director on a specific date in November, 2016, regarding staff to resident physical abuse. The CI report indicated that resident #020 was provided with rough care and felt bullied and afraid of PSW #106. See WN #1 for additional details.

Inspector #542 reviewed the home's investigation file and the employee's file and noted a letter dated five days prior to the CI report that was submitted to the Director, indicating that PSW #106 was alleged to have verbally abused an unidentified resident. Inspector #542 interviewed RPN #122 who indicated that they provided the letter to the RN in charge. The home's investigation notes did not include a thorough investigation of the alleged verbal abuse of a resident. Inspector #542 also found another letter. It was documented that RPN #122 overheard resident #039 telling PSW #106 not to be so rough.

On January 25, 2017, Inspector #542 met with the Administrator who verified that the home did not complete the investigation of either of the letters of concerns.

On January 26, 2017, Inspector #542 interviewed RPN #122, who verified that they were not interviewed regarding the letters of concern regarding PSW #106. [s. 23. (1) (a)]

2. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A CI report was submitted to the Director on a specific date in December, 2016, regarding staff to resident physical and verbal abuse. It was alleged that RPN #107 was verbally and physically abusive towards resident #021, #022 and #023.

The CI report was amended the day after it was submitted, and indicated that RPN #107 continued to be off work, pending the outcome of the investigation.

Inspector #542 interviewed the DOC. Inspector #542 asked what the outcome of the investigation was regarding the CI report. They indicated that RPN #107 received disciplinary action. They also stated that RPN #107 had been back to work for

approximately one week. The Inspector asked if the CI report was amended to notify the Director of the results of the investigation. The DOC indicated that the home did not notify the Director as they were made to believe that the Director could not be notified after 21 days. [s. 23. (2)]

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 every alleged, suspected, or witnessed incident that the licensee knows of, or that is reported is immediately investigated: abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations, to be implemented voluntarily.

WN #4: 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 the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director, improper or

incompetent treatment of care of a resident that resulted in harm or risk of harm and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A CI report was submitted to the Director on a specific date in November, 2016, regarding staff to resident physical abuse. The CI report indicated that resident #020 was provided with rough care and felt bullied and afraid of PSW #106. See WN #1 for additional details.

Inspector #542 reviewed PSW #106's employee file, along with the home's investigation file. Upon review of the files, Inspector #542 noted that two other allegations of abuse involving two different residents were also part of the employee's file. A letter from RPN #122 indicated that PSW #106 provided resident #038 with improper personal care and verbally abused another unnamed resident. Another letter was also located in the files. The letter indicated that RPN #122 overheard resident #039 tell PSW #106 not to be so rough. Inspector #542 also located an interview that was conducted with another resident, resident #012 as this resident also had concerns regarding PSW #106. Resident #012 indicated that PSW #106 provided care too fast and that they were rushed. Resident #012 stated that they did not want PSW #106 to care for them anymore.

On January 25, 2017, Inspector #542 interviewed the DOC regarding the submitted CI report involving resident #020. Inspector #542 asked if a CI report was submitted regarding all of the other allegations of verbal and physical abuse that were found in the home's investigation file. The DOC indicated that because the home had received the other letters around the same time as the submission of the CI report regarding resident #020, that they combined the other allegations in with the CI report.

Inspector #542 noted that the CI report, did not include any information regarding the two additional letters involving resident #038 and #039. Nor did the CI report include any information regarding the home's investigation of these two additional letters. The CI report also did not include any information regarding resident #012's complaints of feeling rushed and PSW #106 and provided care that was too fast.

On January 25, 2017, Inspector #542 interviewed ADOC #102. They indicated that they should have submitted a CI report regarding the letter of concern regarding PSW #106 verbally abusing a resident; however, they failed to do so. [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 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. (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. (3) Unlawful conduct that resulted in harm or a risk of harm to a resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

Inspector #612 reviewed a CI report submitted to the Director in December, 2015, related to a fall resident #033 sustained. The resident was found on the floor and was sent to hospital for further assessment where they determined that the resident had sustained an injury and required surgery.

The Inspector noted that the CI report stated that the home was currently conducting an investigation to determine the events that led up to the unwitnessed fall.

Inspector #612 reviewed the CI report and noted that the Director requested that the home amend the report on April 27, 2016, to include the history of falls over the past six months and falls risk measures in place at the time of the falls. The Inspector was unable to locate the requested information in the CI report.

On January 27, 2017, Inspector #612 and #620 interviewed the DOC who confirmed that the report was not amended to include the events that lead up to the unwitnessed fall as requested by the Director. [s. 107. (4) 1.]

2. The licensee has failed to ensure that the report to the Director included the outcome or current status of the individual or individuals who were involved in the incident.

Inspector #612 reviewed a CI report, see section one of this WN for additional details. The Inspector noted that the Director requested that the home amend the report on April 27, 2016, to include the outcome of the home's internal investigation to determine the cause of the fall and the resident's current health status.

The Inspector noted that the report was amended and stated that the resident's condition had deteriorated. The report stated that the family had an appointment with the DOC to discuss the events leading up to the fall.

On January 27, 2017, Inspector #612 and #620 interviewed the DOC who stated that the resident's health status had improved over time. The DOC did not update the CI report to reflect the change in health status, nor did they amend the report to include the information requested by the Director. [s. 107. (4) 3. v.]

3. The licensee has failed to ensure that the report to the Director included the analysis and follow-up action, including the long-term actions planned to correct the situation and prevent recurrence.

Inspector #612 reviewed a CI report, see section one of this WN for additional details. The Inspector noted that the Director requested that the home amend the report in April 24, 2016, to include the long-term plan of action to prevent recurrence as per the plan of care.

The Inspector reviewed the CI report and noted that under the question "what long-term actions are planned to correct this situation and prevent recurrence" the DOC indicated that they were meeting with the family to look at the events that occurred leading to the fall and would discuss interventions to prevent re-occurrence with the family. The falls team would review current interventions in place as well and determine if there were any gaps in preventing further falls. If needed, a special care conference would be held to look at whether there were further interdisciplinary actions that could be put in place.

On January 27, 2017, Inspector #612 and #620 interviewed the DOC who stated that they met with the family to discuss the fall. They stated that they did not update the CI report to include the long-term actions to correct the situation and prevent recurrence. [s. 107. (4) 4. ii.]

Issued on this 9th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH CHARETTE (612), ALAIN PLANTE (620), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2017_565612_0004
Log No. / Registre no:	012324-16, 024558-16, 024827-16, 025212-16, 025805-16, 028273-16, 028491-16, 029639-16, 030222-16, 030301-16, 031243-16, 031391-16, 031675-16, 031773-16, 031788-16, 031896-16, 032403-16, 032504-16, 032878-16, 033059-16, 033076-16, 033705-16, 034162-16, 035085-16, 035286-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 4, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tracy Lamirande

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To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) Ensure that all residents are protected from abuse by anyone and free from neglect by the licensee or staff and,

b) Specifically ensure that residents are protected from any other abuse or neglect by PSW #106.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident (CI) report was submitted to the Director on a specific date in November, 2016, regarding staff to resident physical abuse. The CI report indicated that resident #020 had reported to their family member that they were provided with rough care and felt bullied and afraid of PSW #106. Resident #020's family member reported this information to the home on the same date the CI report was submitted to the Director.

On January 24, 2017, Inspector #542 reviewed the home's investigation files regarding the above CI report along with PSW #106's employee file. The home placed PSW #106 on a paid leave on the same date the CI report was submitted to the Director, until the investigation was completed. The home's investigation revealed that witnesses described PSW #106's approach to be aggressive, rushed and disrespectful. A letter was located on PSW #106's employee file where they were provided with disciplinary action due to the above incident.

Upon review of PSW #106's employee file and the home's investigation file regarding the above CI report, Inspector #542 located the following:

1. A letter of concern dated five days prior to the CI report submitted to the Director from RPN #122, indicated that PSW #106 had provided resident #039 with improper personal care and verbally abused a resident. It was also documented in the letter that residents were not happy with PSW #106.

2. Investigation notes dated four days prior to the CI report submitted to the Director, indicated that the home spoke to resident #012 as they had concerns about PSW #106. Resident #012 had described physical actions of PSW #106 towards them. Resident #012 indicated that they did not want PSW #106 to care for them anymore.

3. A letter of concern dated the same date that the CI report was submitted from RPN #122, addressed to ADOC #102, indicated that while PSW #106 was providing care to resident #039, RPN #122 overheard resident #039 telling PSW #106 that they don't have to be so rough.

A) On January 25, 2017, Inspector #542 interviewed the DOC regarding the three allegations mentioned above regarding PSW #106. The DOC indicated that because the home had received the other letters around the same time as the submission of the CI report regarding resident #020, that they combined the other allegations in with the CI report. Inspector #542 reviewed the CI report and noted that it did not contain any residents, other than resident #020, furthermore there was no description of the three other allegations.

Inspector #542 interviewed ADOC #102 regarding the three allegations mentioned above and they verified that the home did not immediately inform the Director of the allegations of abuse.

On January 25, 2017, Inspector #542 interviewed the Administrator regarding the letter dated five days prior to the CI report submitted to the Director, and they confirmed that the information was not reported to the Director.

According to the LTCHA, 2007, s. 24, 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: 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. Please refer to WN # 4.

B) Inspector #542 reviewed the investigation notes provided by the home related to PSW #106. The Inspector was unable to locate the following:
- Any investigation notes related to the alleged verbal abuse of an unidentified resident
- Any investigation notes related to the concerns that resident #012 made regarding the physical actions of PSW #106 and not wanting PSW #106 to provide care for them anymore.
- Any investigation notes related to the letter of concern which alleged that resident #039 had told PSW #106 that they were too rough.

On January 27, 2017, Inspector #542 interviewed PSW #106 and asked them about the verbal abuse of an unidentified resident. PSW #106 indicated that the home did not speak to them about the alleged incident.

On January 26, 2017, Inspector #542 interviewed the Administrator regarding the alleged verbal abuse of a resident. The Administrator stated that the home did not further investigate the alleged incident when it was brought forward and that the home failed to complete a thorough investigation. The Administrator also stated that the home did not further investigate the letter of concern which alleged that a staff member overheard resident #039 say to PSW #106 that they were too rough.

Inspector #542 interviewed ADOC #102 regarding the alleged incidents. The ADOC stated that they did not complete their investigation regarding the alleged verbal abuse of an unidentified resident. They indicated that they did not speak with PSW #106 regarding the allegation that resident #039 said PSW #106 provided rough care; however, they had attempted to speak with resident #039. They were unable to provide any investigation documents.

In an interview with RPN #122 on January 26, 2017, they stated that the home did not speak to them regarding the concerns they had brought forward including the alleged verbal abuse of an unidentified resident and when they overheard resident #039 saying that PSW #106 was too rough when providing care. RPN #122 informed the Inspector #543 that they had also reported the second concern to RN #129 and they instructed RPN #122 to document it.

According to the LTCHA, 2007, s. 23, every licensee of a long-term care home

shall ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone. See WN #3 for further details.

The decision to issue this compliance order was based the severity, scope and compliance history. The severity, which was a potential for harm, was increased to actual harm since abuse is identified as a key risk indicator. The scope was isolated and the previous compliance history for LTCHA, s. 19., included a previous compliance order issued during RQI #2016_391603_0007, which was complied October 14, 2016, and a VPC issued during CIS inspection #2016_282543_0002. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Charette

Service Area Office /
Bureau régional de services : Sudbury Service Area Office