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
Oct 31, 2016	2016_178624_0028	005282-16, 011536-16, 012888-16, 017497-16	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 PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

BAIYE OROCK (624)

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): September 19, 20, 21, 22 and 23, 2016.

The following logs were inspected related to alleged staff to resident abuse or neglect: 017497-16, 005282-16, 012888-16 and 011536-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents. A review was also done of the Home's internal investigations and relevant policies and procedures related to abuse.

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.
- **4 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. 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 :

The licensee failed to comply with it's policy on Zero Tolerance of Resident Abuse and

Neglect Program (Policy number RC-02-01-01).

According to Ontario regulation 79/10 sections 2, verbal abuse is defined as follows: Verbal abuse is "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 Licensee's policy on Zero Tolerance of Resident Abuse and Neglect Program, policy number RC-02-01-01, lastly updated in April of 2016, indicates the following:
In the section related to Response and Reporting, it states: "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 the time."

The Abuse and neglect decision tree of the same policy indicated that when there have been a suspected or witnessed abuse and support and reassurance has been provided to the resident(s),
"Staff must report the suspected and/or witnessed neglect or abuse immediately to their supervisor. Staff must also write a factual account of their observation with dates and times of observations included as well as the names of any other individuals/witnesses involved", then the "DOC/RSCM/designate must notify SDM/POA or any other individual identified by the resident of the incident. The Date, time and brief summary of this notification discussion must be documented." Following that, the "Supervisor immediately reports to the Director of Care/Resident Care Manager/designate who then notifies the Provincial regulatory body."

Related to log # 017497-16,

Resident #001 was admitted into the Long Term Care Home on a specified date with a specified diagnosis. On a given date and time, PSW #111 reported to RN Supervisor #113 that five days earlier, during the provision of care, PSW #111 heard PSW #112 speak to resident #001 using foul language and in a degrading manner. PSW #111 therefore failed to report this allegation of verbal abuse immediately to the supervisor as PSW #111 waited five days after the alleged occurrence of the incident to report the allegation to a supervisor.

In an interview with PSW #111 by Inspector #624 a specified date, the PSW #111

indicated that the home's expectation regarding reporting suspected or alleged abuse is that once any staff member becomes aware of abuse or neglect of a resident, that staff member must report immediately to the immediate supervisor. PSW #111 indicated she only reported the alleged abuse to the RN Supervisor #113, five days later.

In an interview with the DOC by Inspector #624 about the incident she indicated that PSW #111, failed to comply with the home's policy on Zero Tolerance of Resident Abuse and Neglect by not immediately notifying the immediate supervisor of a suspected incident of verbal abuse of resident # 001.

WN #2: 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).

Findings/Faits saillants :

The Licensee failed to immediately investigate an allegation of verbal abuse of resident #001.

Related to log #017497-16 regarding the same resident and incident above,

The RN Supervisor #113 became aware of the allegation of staff to resident verbal abuse of resident #001 on a specified date. The investigation into the allegation of verbal abuse of resident #001 was not initiated until six days later, which was not immediate.

WN #3: 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 :

The licensee failed to immediately notify the Director of an allegation of verbal abuse of resident #001.

Related to log #017497-16 regarding the same resident and incident above,

The RN Supervisor #113 became aware of the allegation of verbal abuse of resident #001 on a given date but the allegation was not reportedly to the Director until six days later, which was not immediately as legislated.

In an interview with the DOC conducted by Inspector #624 on a specified date and time, she indicated that the Home's expectation on reporting abuse and neglect is that PSWs report to either the RN or the RPN and the RPN or RN reports to her, the Administrator or a designated on-call Manager who then notifies the Director. She also indicated that the Charge RN all have the numbers to call the Director but the procedure is that they will call either herself, the Administrator or a designated on-call manager who then notifies the Director.

WN #4: 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 :

The licensee failed to ensure that resident #001's Substitute Decision Maker (SDM) was immediately notified of an allegation of verbal abuse of the resident.

Related to log #017497-16 regarding the same resident and incident above,

The allegation of verbal abuse was not reported to the resident's SDM until six days after the RN Supervisor #113 became aware and informed the DOC.

In an interview with the DOC conducted by Inspector 624 on a specified date, she indicated that as soon as the home becomes aware of any incidents of abuse or alleged abuse, the resident's SDM is to be notified immediately, updated about the home's investigation and then informed of the outcome of the investigation as soon as the investigation is completed.

The RN Supervisor #113 became aware of the allegation of verbal abuse of resident #001 on a specified date but the resident's SDM was notified of the allegation six days later, which was not immediately.

Issued on this 1st day of December, 2016

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

Original report signed by the inspector.