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 25, 2017	2017_639607_0009	008200-17	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 OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

JULIET MANDERSON-GRAY (607)

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): May, 15, 16 and 18, 2017.

During this Critical Incident inspection the following intake was inspected: Log # 008200-17.

Summary of Intakes:
1) 008200-17: A Critical Incident Report (CIR), regarding an alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents.

During the course of the inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed training records, evaluation of the abuse and responsive behaviour programs, home specific policies related to responsive behaviours and Resident Abuse, Resident Rights and Commitment to Residents.

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)**
- **2 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 :

1. The Licensee failed to ensure their Zero Tolerance of Resident Abuse and Neglect:

Response and Reporting policy #RC-02-01-02 was complied with related to resident #001 and #002.

Related to Log #008200-17 involving resident #001 and #002:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, for an alleged resident to resident sexual abuse that occurred on an identified date and time. The CIR indicated a Personal Support Worker (PSW) witnessed resident #001 seated in a specified area with resident #002. Resident #001 was observed touching resident #002 inappropriately.

Review of the Licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy #RC-02-01-02 directs:
All staff
1) Immediately respond to any form of alleged, potential, suspected or witnessed abuse (physical, verbal, emotional, sexual, financial and neglect).
REPORTING
1. Any employee or person becomes aware of an alleged, suspected or witnessed 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.

A review of the Licensee's internal investigation notes indicated there was a video footage of the specified area where resident #001 and #002 were seated in April 2017. Further review of the investigation notes, indicated that during the above identified incident, PSW #116 was witnessed passing by the specified area at two identified times, where the residents were seated.

Interview with PSW #117, indicated at an identified time and date, the PSW had witnessed resident #001 sitting in the specified area, touching a specified area of resident #002's, and had reported the incident to an unidentified PSW. Personal Support Worker #117 indicated the unidentified PSW had reported to him/her, witnessing a similar incident involving resident #001 and #002 earlier during the shift. The PSW #117 reported the incident to the Supervisor.

Interview with PSW #116 indicated that he/she had witnessed resident #001 inappropriately touching resident #002's, prior to a meal hour. The PSW indicated that he/she had forgotten to report this to Registered Practical Nurse #118. PSW #116

indicated it was when PSW #117 had brought forward the incident to his/her attention, they both brought this forward to Registered Practical Nurse (RPN) #118, and this was close to the end of his/her shift. Personal Support Worker #116 further indicated that the incident should have been reported to the RPN #118 immediately, and this was not done, as he/she had forgotten to report the incident, at the time he/she had witnessed it.

Interview with the Director of Care (DOC), indicated that it is the home's expectation that any incident of witnessed, suspected or alleged abuse must be reported immediately, and further indicated, PSW #116 did not report the above identified incident immediately.

The Licensee failed to ensure that their Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy #RC-02-01-02 was complied with, specifically related to the reporting of any alleged, potential, suspected or witnessed sexual abuse, involving to resident #001 and #002. [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 ensuring that their Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy #RC-02-01-02 was complied with, specifically related to resident #001 and #002, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers were identified for resident #002 in response to the resident's ongoing responsive behaviours, and failed to ensure that strategies were developed and implemented to respond to the resident's behaviours.

Related to Log #008200-17 involving resident #001 and #002:

A review of the progress notes for a three month period, indicated there were several incidents of responsive behaviours by resident #002 that were directed towards other residents.

Observations of resident #002 during the inspection indicated the resident is cognitively well, and ambulates independently around the unit with no mobility aid. No responsive behaviours were noted during the inspection.

Interview with PSW #110, indicated to the Inspector that resident #002 often exhibits responsive behaviours towards resident #003, and indicated that he/she feels there is some jealousy between the two residents. PSW #110 indicated resident #002 behaviours is triggered by resident #003, especially if resident #002 receives a visitor, this could initiate responsive behaviours between the two residents.

Interview with PSW # 113 indicated resident #002 exhibited three identified responsive behaviours. The PSW indicated that resident #003 is often resident #002's trigger. PSW #113 indicated he/she does not interfere when both residents are exhibiting responsive behaviours.

Interview with PSW #114 indicated to the Inspector that when resident #002 exhibit responsive behaviours, it is usually because of resident #003, especially if resident #002 does not follow resident #003's directions. The PSW and further indicated that both residents should not be sharing the same room. He/she indicated that resident #002 exhibits responsive behaviours, and indicated staff would redirect both residents, and if redirection does not work he/she would report this to nurse in charge.

Interview with RPN #115 by the Inspector, indicated that resident #002 has several responsive behaviours. The RPN further indicated that resident #002's responsive behaviours can be easily triggered by conversations with resident #003, and indicated staff would redirect and administer as needed medications to resident #002 when the responsive behaviours are exhibited. The RPN further indicated the behaviours with resident #002's is addressed by separating and redirecting both residents, and indicated that this not always effective, as both resident often seek out each other.

A review of the written plan of care currently in place for resident #002 failed to identify the responsive behaviours exhibited by the resident, despite the resident displaying these responsive behaviours.

Interview with ADOC and DOC, indicated it is the home's expectation that if residents are exhibiting responsive behaviours, the Behaviour Support Ontario (BSO) team would assess these residents and ensure that the residents plan care reflect identified triggers and interventions.

The licensee failed to ensure that when resident #002 demonstrates ongoing responsive behaviours towards other residents, the behavioural triggers are identified and strategies were developed and implemented to respond to the responsive behaviours and the identified triggers and strategies were identified in the written plan of care. [s. 53. (4) (a)]

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 ensuring that behavioural triggers were identified for resident #002 in response to the resident's responsive behaviours, and strategies were developed and implemented to respond to the resident's behaviours, to be implemented voluntarily.

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. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to Log #008200-17 involving resident #001 and #002:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, for an alleged resident to resident sexual abuse that occurred on an identified date and time.

A review of the CIR and Ministry of Health and LongTerm Care (MOHLTC) after hours report, indicated the above identified incident was report to the MOHLTC after hours on an identified date and time. In addition, a review of the CIR indicated a preliminary report was not submitted to the Director until 11 days later.

The licensee failed to ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, specifically related to submitting a report to the Director 11 days after an incident of an alleged resident to resident sexual abuse, involving resident #001 and #002. [s. 104. (3)]

Issued on this 26th day of May, 2017

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

Original report signed by the inspector.