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

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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 17, 2020	2020_838760_0016	014832-20	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 Scarborough
3830 Lawrence Avenue East SCARBOROUGH ON M1G 1R6

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

JACK SHI (760)

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): August 5, 6, 7, 2020.

Log #014832-20, CIS #2117-000016-20 was related allegation of staff to resident abuse.

A Complaints inspection #2020_838760_00015 was conducted concurrently with this Critical Incident Systems inspection.

During the course of the inspection, the inspector reviewed records, interviewed staff and conducted observations.

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

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.
- **3 WN(s)**
- **3 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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 failed to ensure that the results of the investigation related to the allegations of physical and verbal abuse in resident #002, 003 and 004 from PSW #110 were reported to the Director.

A Critical Incident Systems (CIS) report was submitted by the home indicating that PSW #105 witnessed alleged incidents of physical and verbal abuse towards residents #002, 003 and 004 from PSW #110. A record review of the CIS report indicated that the home completed their investigation and that PSW #110 was disciplined. The CIS report did not mention whether the allegation of resident abuse was substantiated or not. The CIS report was completed by DOC #103.

An interview with DOC #103 indicated that the alleged incidents of physical and verbal abuse to resident #002, 003 and 004 from PSW #110 was substantiated. DOC #103 indicated that their practice of submitting CIS reports would be that if no abuse took place, they would indicate that in the report but if the allegation of abuse was substantiated, they would not put that in the CIS report.

The home failed to ensure that the results of their investigation of the alleged incidents of physical and verbal abuse towards resident #002, 003 and 004 from PSW #110 were reported to the Director. [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 shall ensure to 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), to be implemented voluntarily.

WN #2: 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 failed to ensure that the staff of the home immediately reported the witnessed incidents of physical and verbal abuse from PSW #110 to resident #002, 003 and 004 and neglect of resident #005 to the Director.

A CIS report was submitted by the home indicating that PSW #105 witnessed alleged incidents of physical and verbal abuse towards residents #002, 003 and 004 from PSW #110. The CIS report indicated that PSW #105 did not want to report these incidents right after they occurred.

A record review of the home's investigation record indicated that PSW #105 was aware of the whistle blower policy at the home, where they are protected from reporting something but PSW #105 indicated another reason to why they did not report immediately.

An interview with a PSW staff in the home stated they did not report the allegations of abuse immediately because of an identified incident that occurred in the past. PSW #109 was also interviewed and could not properly identify what the whistle blowing protections were at the home.

PSW #107 was interviewed and indicated that they were notified about the alleged incidents of resident abuse by PSW #110 from PSW #105, right after PSW #105

witnessed these incidents of resident abuse from PSW #110. After a period of hearing about the last incident of resident abuse from PSW #105 by PSW #110, PSW #107 eventually reported the allegations to RPN #104 but did not know if RPN #104 did anything to respond to the allegations. PSW #107 also stated that it was the RPN's responsibility to forward those concerns to DOC #103. RPN #106 was unavailable to be interviewed. PSW #107 does not recall any exact dates and times of when they heard and reported the allegations of resident abuse by PSW #110 from PSW #105.

PSW #108 mentioned about the neglect that resident #005 sustained when they attempted to ring the call bell and PSW #110 ignored it and told PSW #108 to not attend to resident #005 since their shift did not start yet. PSW #108 mentioned they did not report this incident to anyone.

An interview with DOC #103 confirmed that PSW #105 did not report the allegations of physical and verbal abuse to resident #002, 003 and 004 from PSW #110 immediately due to an identified reason. PSW #105 was reminded by DOC #103 about the whistle blower protections policy at the home and reporting requirements of resident abuse. DOC #103 confirmed that the staff of the home failed to ensure that they immediately reported allegations of verbal and physical abuse towards resident #002, 003 and 004 from PSW #110.

The home failed to ensure that the alleged allegations of physical and verbal abuse of resident #002, 003 & 004 and alleged allegation of neglect of resident #005 from PSW #110 was reported immediately to the Director. [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 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. 4. Misuse or misappropriation of a resident's money. 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), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of an alleged incident of physical and verbal abuse with resident #002, 003 and 004.

A record review of the CIS report did not indicate whether a police force was contacted in relation to the allegations of physical and verbal abuse that resident #002, 003 and 004 sustained from PSW #110.

PSW #107 and PSW #105 were interviewed and could not recall whether the police were contacted related to the allegation of physical and verbal abuse from PSW #110 but stated they should have. PSW #105 indicated that the home normally would call the police related to similar allegations of resident abuse. PSW #108 also stated they were unaware if the police were involved in this allegation of abuse.

An interview with DOC #103 stated that the police were not involved because of an identified reason. DOC #103 did state that the police should have been contacted about these allegations of resident abuse.

The home failed to ensure that the appropriate police were informed of the allegation of physical and verbal abuse from PSW #110 towards resident #002, 003 and 004. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 18th day of August, 2020

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

Original report signed by the inspector.