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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Aug 24, 2015	2015_195166_0018	O-001992-15, 002218-15, 001684-15, 002357-15	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North OSHAWA ON L1J 4L1

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

CAROLINE TOMPKINS (166)

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 10 ,11, 12, 2015

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Social Worker, RAI Coordinator, Acting Administrator, Director of Care, Assistant Director of Care, Behaviourial Support Staff,Registered Practical Nurses and Personal Support Workers.
During the course of the inspection, the inspector reviewed clinical documentation, the licensee's investigation documentation and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 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. Log O-002357-15

The licensee has failed to ensure that the behavioural triggers have been identified for the resident demonstrating responsive behaviours.

Review of clinical documentation and interviews with the Director of Care, Registered Practical Nurses and Personal Support Workers indicated that Resident #8 began to demonstrate responsive behaviours related to inappropriate sexual comments and sexual touching directed towards other residents, specifically Resident#5,and Resident #7, shortly after admission to the home.

Resident #8, had four documented incidents of inappropriate sexual comments and attempts of inappropriate sexual touching directed towards Resident #5, one documented incident of non consensual kissing of a co-resident and one documented incident of inappropriate sexual touching of Resident #7.

There is no evidence to indicate that any behaviour triggers have been identified related to Resident #8's responsive behaviours of inappropriate sexual comments and and inappropriate sexual touching. [s. 53. (4) (a)]

2. Log O-002357-15

The licensee has failed to ensure that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours

Review of clinical documentation and interviews with the Director of Care, Registered Practical Nurses and Personal Support Workers indicated that Resident #8 began to demonstrate responsive behaviours related to sexual comments and sexual touching directed towards other residents, specifically Resident #5 and Resident #7 shortly after admission to the home.

There is no evidence to indicate that any strategies had been developed and implemented to respond or to mitigate Resident #8's responsive behaviours of inappropriate sexual comments and inappropriate sexual touching directed towards other residents. [s. 53. (4) (b)]

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 all behavioural triggers are identified and that strategies are developed and implemented to respond to Resident#8, who is demonstrating inappropriate sexual responsive behaviours, including inappropriate sexual comments and inappropriate sexual touching, to be implemented voluntarily.

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).

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 :

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 :

1. Log O-002218-15

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident(CIR) was received reporting a resident to resident physical assault which had occurred on a specified date and time, between Resident #1 and Resident #2.

Review of the CIR, clinical documentation and interview with the Director of Care and Registered Practical Nurse indicated that on a specified date and time, Resident #1 and Resident #2 were overheard in a verbal and physical altercation. Staff separated the residents.
Resident #2 sustained some injuries due to the altercation. Resident #1 did not sustain any injuries.

The Director was not notified of the resident to resident physical altercation which caused injury to Resident #2 until one day post incident. [s. 24. (1)]

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Issued on this 24th day of August, 2015

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

Original report signed by the inspector.