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
Dec 17, 2019	2019_694166_0027	008703-19, 011716-19, 019450-19, 021548-19	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 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): November 26, 27, 28, 29, December 3, 2019.

Logs #08703-19, #011716-19, #019450-19, and #021548-19, related to allegations of staff to resident abuse were inspected concurrently during this inspection.

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

During the course of this inspection, the Inspector observed staff to resident interactions, reviewed the licensee's investigation documentation, specified residents' clinical health records, staff education records and the licensee's policy related to Zero Tolerance of Resident Abuse and Neglect: Response and Reporting.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

- **1 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	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. 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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to resident #006:

A Critical Incident Report (CIR) was submitted to the Director, reporting an incident of staff to resident abuse. The incident occurred on a specified date and was not reported to the licensee until one day post incident.

Review of the CIR documentation, by Inspector #166, indicated resident #006 had confided to a family member on the day of the incident, regarding the staff to resident abuse by Personal Support Worker (PSW) #102, when the resident had asked to be toileted.

Review resident #006's clinical health records and the licensee's investigation documentation by Inspector #166, during the course of this inspection, indicated that resident #006 had requested assistance for toileting from PSW #102. The resident's family member was present in the room and PSW #108 was assisting PSW #102, when the staff to resident abuse occurred. The resident would not disclose what PSW #102 had said. The witness statement from PSW #108, indicated resident #006 was upset over the interaction.

Review of the licensee's investigation and in separate interviews with Inspector #166, the Administrator and the Director of Care (DOC) indicated resident #006 had reported this incident to PSW #106. Resident #006 and the resident's family member also reported the incident to Registered Practical Nurse (RPN) #107 on the date of the incident.

Review of the licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy, RC-02-01-02, directed staff to ensure :
Any employee or persons who becomes aware of the 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 that time.

The licensee has failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents and directs staff to immediately report any alleged, suspected or witnessed resident abuse was complied with. An incident of staff to resident abuse, directed towards resident #006 by PSW #102, occurred on a specified

date. It was not until the day after the interaction between PSW #102 and resident #006 that the licensee was made aware of the incident.

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 staff are aware of the licensee's written policy to promote zero tolerance of abuse and neglect of residents and of their responsibility to ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 31st day of December, 2019

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

Original report signed by the inspector.