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
May 2, 2022	2022_946111_0007	009807-21, 011997-21, 013952-21, 014845-21, 000624-22	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

LYNDA BROWN (111), CRISTINA MONTOYA (461)

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): February 22 to 25, 28, March 1 to 4, 2022.

The following critical incidents were inspected concurrently during this inspection:
-Log #014845-21 (CI #2439-000027-21) related to alleged staff to resident improper care,
-Log #011997-21 (CI #2439-000025-21) and Log # 009807-21 (CI #2439-000011-21) related to alleged staff to resident physical abuse.

The following critical incidents were inspected concurrently during this inspection and non-compliance was identified under the complaint inspection report #2022_946111_0006: Log # 000624-22 (CI #2439-000003-22) and Log # 018004-21 (CI #2439-000032-21) related to medication incidents and/or missing/unaccounted for controlled substances.

The following critical incidents were inspected concurrently during this inspection and non-compliance was identified under the follow-up inspection report #2022_946111_0005: Log #021221-21 (CI # 2439-000036-21) related to a disease outbreak and Log #013952-21 (CI#2439-000025-21) related to an environmental hazard.

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of Care (a-DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) reviewed: resident health records, home's investigations, reviewed staff schedules and the following policies: Zero Tolerance of Abuse and Neglect.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation

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

4 WN(s)
4 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. (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 :

The licensee failed to ensure that an allegation of abuse of resident #008 by a staff member, was immediately investigated.

Resident #008 reported to an RN that a staff member had been abusive towards them and resulted in an injury. On another date, the resident reported to an RPN that a staff member had been abusive towards them and no injury was noted. The RPN did not report the incident to the RN, DOC or the resident's SDM. The RPN confirmed that they did not immediately initiate an investigation after the resident reported the allegation of abuse by a staff member. The ADOC initiated an investigation into the allegation after they became aware of the allegation by the resident's SDM, a number of days later.

Sources: resident #008's health record, CI and interview with staff.

2. The licensee has failed to ensure that the report to the Director included the results of the investigation of an alleged staff to resident #007 neglect.

The home reported to the Director an alleged neglect of resident #007 by staff . The home’s investigation did not indicate the results of the investigation or whether the results were reported to the Director. The ADOC indicated the investigation had been completed by the home's previous DOC and had no documented record of when that occurred.

Sources: CI, resident #007 health record, the home’s investigation, interview of resident #007 and their SDM, and interview of staff.

3. The licensee has failed to ensure that the report to the Director included the results of the investigation of an alleged staff to resident #008 abuse.

Resident #008 reported to an RN that a staff member had been abusive towards them and resulted in an injury. The resident reported a second incident of staff to resident abuse to an RPN. Both incidents were reported to the Director, but there was no indication that the results of the investigations into both incidents were reported to the Director. The home’s investigation also did not include the results of the investigation for both incidents. The ADOC reported that the previous DOC had completed the investigations for both incidents and had no documented evidence of the results of the investigation.

Sources:CI, resident #008's health record, home’s investigation and interview with staff.

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 (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; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect neglect of resident #007 by a staff member, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #007's substitute decision-maker (SDM) reported an alleged staff to resident neglect to the DOC. The report to the Director was not submitted until a number of days later, when the SDM reported the allegation to the licensee (Regional Director). The DOC involved in the investigation was no longer in the home.

Sources: CI, resident #007 health record, the home's investigation and interview with staff.

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of resident #008 by a staff member, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #008 reported an allegation of staff to resident abuse to an RPN, the RPN assessed the resident and there were no injuries noted. The RPN did not immediately report the allegation to their immediate supervisor or the Director. Resident #008's progress notes also revealed that a second allegation of staff to resident abuse was reported to an RPN. The RPN changed the PSW assignment for the day and requested two staff members to provide care at all times and documented the incident. That allegation was not reported. The ADOC reported the first allegation of staff to resident abuse was reported to the Director but not the second allegation.

Sources:CI, resident #008's health record and interview with staff.

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 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, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #008 and resident's Substitute Decision Maker (SDM), were notified of the results of the investigation into an alleged staff to resident neglect, immediately upon the completion.

Resident #008 reported to an RN, an allegation of staff to resident abuse, that resulted in an injury to the resident. The resident reported a second allegation of staff to resident abuse to an RPN and no injuries were noted. There was no documented evidence that the resident's SDM were notified of the results of the investigations upon completion for either of the allegations. The ADOC indicated that the former DOC completed the investigations and confirmed there was no documented evidence to support the resident's SDM were notified of the results of the investigation.

Sources: two CI's, resident #008 health record, the home’s investigation and interview with staff.

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 resident and the resident’s substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #4: 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. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the names of any staff members who were present with an allegation of neglect of resident #007.

The licensee reported an allegation of staff to resident neglect that was made by resident #007's SDM. The report submitted to the Director, did not include the names of the staff who were involved in the neglect. The staff involved in the allegations were not available for an interview. The ADOC could not provide the information as the previous DOC completed the investigation.

Sources: review of the home's investigation, CI and interview with staff.

2. The licensee has failed to ensure that the report to the Director included the names of any staff members who were present during two separate incidents of staff to resident #008 abuse.

The home reported to the Director, an allegation of staff to resident abuse towards resident #008. Resident #008 reported to RN #117 that on June 18, 2021, a staff member had hit them in the face with the call bell and on June 19, 2021, another staff member had grabbed their wrist, resulting in a small scratch. The report submitted to the Director,did not include the names of the staff who were involved in the allegation. ADOC #012 was unable to provide the staff involved in the allegations as the former DOC had completed the investigation.

Sources: the home's investigation, CI, and interview with staff.

3. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the incident of alleged neglect of resident #007 and prevent recurrence.

An allegation of staff to resident #007 neglect was reported to the Director and the report did not include long-term actions to correct the situation and prevent a recurrence. The ADOC was not aware of the long-term actions to prevent a recurrence as the previous DOC completed the investigation and was no longer in the home.

Sources: review of the home's investigation, CI, and interview with staff.

4. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the incident of abuse of resident #008 and prevent recurrence.

Resident #008 reported to an RN a staff to resident abuse that had occurred and resulted in an injury to the resident. The resident reported a second allegation of staff to resident abuse to an RPN but no injuries were sustained during that incident. The report to the Director for both incidents did not include the long-term actions taken to prevent a recurrence. The ADOC indicated they were unaware of the long-term actions taken to prevent recurrence for both incidents of staff to resident abuse incidents as the previous DOC had completed the investigation and was no longer in the home.

Sources: review of the home's investigation, two CIS reports and interview with staff.

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 in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident; and the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

Issued on this 30th day of May, 2022

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

Original report signed by the inspector.