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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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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
Jun 27, 2019	2019_626501_0012	008988-19, 010919-19	Complaint

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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 4, 5, 6, and 7, 2019. Additionally, an off-site interview was conducted on June 11, 2019.

In this inspection the following intakes were inspected:
#008988-19 related to resident to resident physical abuse; and
#010919-19 related to a complaint regarding the discharge of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Social Worker (SW), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), activity aide (AA), Behaviour Support Ontario (BSO) Leads, Central East Local Health Integration Network (CELHIN) Senior Manager, Community Services Police Officer, Mental Health Support Co-ordinators for the Centre for Addiction and Mental Health (CAMH) and residents.

During the course of the inspection, the inspector reviewed health care records, the home's email communication with external agencies and observed the delivery of resident care and services, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #002 from abuse by resident #001.

A Critical Incident System (CIS) report was submitted by the home indicating resident #001 had identified responsive behaviours and injured resident #002.

According to the most recent plan of care, resident #001 had identified responsive behaviours and was part of the Behaviour Support Ontario (BSO) program in the home.

According to resident #002's written plan of care, the resident was being followed by the BSO team due to identified responsive behaviours.

An interview with RPN #102 who attended to resident #002 on the day of the incident, indicated when they heard the noise they thought it might involve resident #001and #002 due to their known responsive behaviours.

An interview with PSW #104 who witnessed the incident, described resident #001 and #002 as having responsive behaviours. According to PSW #104, resident #002 was always redirected but resident #002 was unable to remember. PSW #104 indicated the intervention to respond to resident #001's responsive behaviours were to leave them alone.

An interview with PSW #105 who was resident #001's care giver on the day of the incident, stated they were providing care to another resident when the incident occurred. According to PSW #105, resident #001 was responding to resident #002. According to PSW #105, resident #002 would often trigger resident #001. According to PSW #105, nothing could keep resident #002 from having an identified responsive behaviour but staff would redirect resident #002 when they were aware.

An interview with RPN #103, who was the temporary lead for the BSO team, stated resident #001 exhibited responsive behaviours and had identified triggers. According to RPN #103, resident #002 would often trigger resident #001 by exhibiting a known responsive behaviour.

An interview with Activity Aide (AA) #106 who often did one on one visits with resident #001 as part of the BSO team, indicated resident #001 had identified responsive behaviours that were triggered by resident #002's responsive behaviour.

An interview with PSW #111 indicated resident #002 would often have responsive behaviours. According to PSW #111 resident #002 could not help themselves and the

intervention was to redirect. PSW #111 was unaware of any other interventions to respond to resident #002's identified responsive behaviour.

An interview with RN #112 indicated resident #002 had an identified responsive behaviour. According to RN #112, an identified intervention proved ineffective. The staff would redirect and monitor resident #002 but were unable to do so at all times. According to RN #112, nothing could keep resident #002 from exhibiting an identified responsive behaviour. RN #112 stated that before the incident, resident #002 required limited assistance with their activities of daily living (ADLs) but due to injury resulting from the altercation, resident #002 required extensive assistance. As well, resident #002 had been mobile previous to the incident but was in an assistive device following the incident. RN #112 also indicated resident #002 suffered another identified injury that was believed to have been a result of the incident.

The home failed to protect resident #002 from abuse of resident #001 as resident #002 had known responsive behaviours that triggered resident #001. [s. 19. (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 resident #002 is protected from physical abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, implementing interventions.

A Critical Incident System (CIS) report was submitted by the home indicating resident #001 had an identified responsive behaviour and an altercation with resident #002. Resident #002 had an ongoing identified responsive behaviour. Resident #002 sustained injuries and was sent to the hospital.

According to the most recent plan of care, resident #001 had behaviours and was part of the Behaviour Support Ontario (BSO) program in the home.

According to the plan of care of an identified date, resident #002 had identified responsive behaviours.

Interviews with RPN #102, RPN #103, PSW #104, PSW #105, PSW #107, PSW #111, and AA #106 indicated resident #001 was known to have an identified responsive behaviour with known triggers including an identified responsive behaviour of resident #002. According to these staff members, the intervention to respond to resident #001's responsive behaviour was to leave the resident. The intervention to respond to resident #002's responsive behaviour was to redirect. According to PSW #105, there was nothing that would keep resident #002 from triggering resident #001. According to PSW #107, resident #002 did not display an identified responsive behaviour at an identified time of the day.

An interview with RN #112 indicated resident #002 had an identified responsive behaviour and was unaware of the cause. According to RN #112, an intervention to prevent resident #002 from triggering resident #001 proved ineffective for identified reasons. The staff would redirect and monitor resident #002 but were unable to do so at all times. According to RN #112 nothing could keep resident #002 from triggering resident #001 and also indicated the identifiefd interventions to address resident #002's responsive behaviours had been discontinued.

An interview with RPN #108 who is the lead for the Behaviour Support Ontario (BSO) team in the home, indicated resident #002's responsive behaviour was related to an identified mood and was considering involving resident #002 in an identified program just

when the incident between resident #001 and #002 occurred. The RPN also indicated other interventions could have been tried and indicated a number of them.

The home was aware resident #001 and #002 had responsive behaviours but failed to implement interventions to minimize the risk of altercation and potentially harmful interactions between the two of them. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145(1), in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

A complaint was made to the Ministry of Health and Long-Term Care regarding the inappropriate discharge of a resident by Extendicare Scarborough.

A Critical Incident System (CIS) report was submitted by the home indicating on an identified date resident #001 had an identified responsive behaviour which resulted in an altercation with resident #002. Resident #002 sustained injuries and was sent to the hospital. Resident #001 was taken to an identified facility.

An interview with the complainant indicated resident #001 was referred to them for alternate accommodations pending identified proceedings. According to a colleague of this complainant, they called the home on an identified date to inform them that resident #001 may be returning to the home. The Director of Care (DOC) #100 and Social Worker (SW) #101 told this colleague that the resident could not return to the home and that according to the Long-Term Care Homes Act (LTCHA), they had no obligation to find the resident another home. The complainant stated that as a result, they attempted to help by interviewing the resident who told them they needed assistance with activities of daily living (ADLs). The complainant stated they contacted the home on an identified date informing them that because resident #001 needed assistance with ADLs, they were not eligible to be placed in an identified program.

According to the complainant, the home's DOC and SW came their office, with the resident's plan of care. The complainant admitted they did not look closely as this document but was told that resident #001 could manage identified ADLs. Based on this information, the complainant proceeded with an alternate temporary accommodation. Identified proceedings indicated resident #001had identified conditions that would preclude them from returning to the home. The DOC then advised the complainant that the resident was officially discharged from the home.

An interview with DOC #100 indicated that they contacted an identified agency, stating that they wanted to discharge resident #001 based on the LTCHA and had been informed that the resident might be sent back. An email was sent from the agency to the

indicating that a representative from the home could attend identified proceedings.

DOC #100 indicated they met with the complainant, who wanted to know the level of care required by resident #001. The DOC stated they brought the resident's written plan of care and tried to show the complainant. The DOC also stated that they told the complainant that resident #001 was independent of identified ADLs. The DOC acknowledged that they never stated resident #001 needed extensive assistance with an identified ADL.

DOC #100 further indicated that the reason the home discharged resident #001 on an identified date, was because SW #101 informed them of identified conditions. A review of resident #001's progress notes indicated that a note was documented on an identified date, by SW #101 outlining these conditions.

Interviews with Administrator #109, DOC #100 and SW #101 indicated they informed the CELHIN (placement co-ordinator) resident #001 was discharged from the home and the reason was related to the above noted conditions. An interview with Senior Manager #110 from CELHIN indicated they were informed by the home that resident #001 was being discharged due to the above information but the home had not collaborated with them to find alternative arrangements.

The licensee discharged resident #001 due to resident #001 having identified conditions as noted above. However, in doing so, failed to collaborate with the appropriate placement co-ordinator (CELHIN) to make alternate arrangements for the accommodation, care and secure environment required by the resident. [s. 148. (2) (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 before discharging a resident under subsection 145(1), in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident, to be implemented voluntarily.

Issued on this 28th day of June, 2019

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

Original report signed by the inspector.