Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 7, 8, 9, 16, 19, 2012	2012_054133_0008	Critical Incident

Licensee/Titulaire de permis

~~NEW ORCHARD LODGE LIMITED~~ JL Extendicare (Canada) Inc JL
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE TENDERCARE
770 Great Northern Road, Sault Ste Marie, ON, P6A-5K7

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the former Director of Care who was the acting Director of Care on March 7th 2012, registered and non registered nursing staff, a housekeeping services staff member, the social worker, a resident programs staff member, residents and a resident's family member.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report and reviewed documentation related to the home's internal investigation into this reported incident, reviewed an employee's personnel file, reviewed the policy to promote zero tolerance of abuse and neglect of residents entitled "Resident Abuse" (reference # RESI-02-06-01, version date September 2011) and reviewed components of the home's orientation and training program.

The inspection occurred on site March 7-8, 2012.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The home's "Resident Abuse" policy (# RESI-02-06-01, version date September 2011) does not clearly set out what constitutes resident to resident physical abuse.
[LTCHA 2007, c.8, s.20(2)b]

2. The home's "Resident Abuse" policy (# RESI-02-06-01, version date September 2011) does not contain an explanation of the duty under section 24 of the Act to make mandatory reports.
[LTCHA 2007, c.8, s.20(2)d]

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 subsections:

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. On a day in November 2011, the licensee became aware of a witnessed incident of staff to resident emotional abuse that occurred on an earlier day in November 2011, involving a Personal Support Worker and a resident. An investigation was immediately conducted and appropriate action was taken in response to the incident.

The licensee immediately reported the witnessed incident of abuse to the Director via a Critical Incident Report but failed to ensure that the results of the abuse investigation were reported to the Director.
[LTCHA 2007, c.8, s.23(2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The home's "Resident Abuse" policy (RESI-02-06-01, Version September 2011) does not identify the training and retraining requirements for all staff on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.
[O. Reg 79/10, s.96 (e)i]

The home's Resident Abuse policy (RESI-02-06-01, Version September 2011) does not identify the training and retraining requirements for all staff on the situations that may lead to abuse and neglect and how to avoid such situations.
[O. Reg 79/10, s.96 (e)ii]
2. The home's "Resident Abuse" policy (# RESI-02-06-01, version date September 2011) does not identify measures and strategies to prevent abuse and neglect.
[O. Reg 79/10, s.96 (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

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 :

1. On a day in November 2011, the licensee became aware of a witnessed incident of staff to resident emotional abuse that occurred on an earlier day in November 2011 involving a Personal Support Worker and a resident. An investigation was immediately undertaken and appropriate action was taken in response to the incident.

On March 7th 2012 the acting Director of Care informed the inspector that the substitute decision maker (SDM) of the resident was not notified within 12 hours of the licensee becoming aware of the witnessed incident of emotional abuse involving this resident.
[O. Reg 79/10, s.97 (1)b]
2. On March 7th 2012 the acting Director of Care informed the inspector that the resident's SDM was not notified of the results of the abuse investigation.
[O. Reg 79/10, s. 97 (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following subsections:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. As per the LTCHA 2007, S.O. 2007, c.8, s76, all staff are to receive retraining in 11 areas including the long term care home's policy to promote zero tolerance of abuse and neglect of residents. O. Reg 79/10, s.219(1) clarifies this retraining is to occur in annual intervals.

A Personal Support Worker (PSW) who was involved in an incident of emotional abuse of a resident on a day in November 2011 did not receive annual retraining in 2011 in the area of the long term care homes policy to promote zero tolerance of abuse and neglect of residents.

During the on site inspection the inspector reviewed print outs of the slide deck for the presentation entitled "Preventing Abuse & Aggression in the Elderly" (dated 1/17/2011). The slide deck represents the annual training staff receive in the area of the home's policy to promote zero tolerance of abuse and neglect of residents and the annual training staff receive in the area of abuse recognition and prevention. The presentation was delivered on several occasions in January 2011 and the PSW did not attend any of the sessions and was therefore required to read the print outs of the slide deck by year's end. The PSW first read the print outs in November 2011 as a result of their discipline related to emotional abuse of a resident.

The presentation contains incomplete and incorrect definitions of abuse and incorrect information about when relatives or guardians are to be notified about resident abuse.

The presentation does refer to an Extendicare policy about abuse and directs staff where to find it. The presentation puts forward several points about the policy in the "What does Extendicare Say?" section such as: there is zero tolerance for abuse, that all incidents of abuse will be investigated, that victims of abuse will be supported, that every individual is required to report abuse and that there will be consequences for anyone who abuses residents. The presentation does not however provide staff with training on the long term care home's comprehensive policy to promote zero tolerance of abuse and neglect of residents.

Issued on this 20th day of March, 2012

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

Jessica Laporsée