



**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 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  
Direction de l'amélioration de la performance et de la conformité

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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
Nov 10, 14, 22, 23, 28, 29, 2011	2011_043157_0030	Complaint

**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 HALIBURTON  
167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0

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

PATRICIA POWERS (157)

**Inspection Summary/Résumé de l'inspection**

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, one Registered Nurse, one Registered Practical Nurse, two Personal Support Workers, one resident.

During the course of the inspection, the inspector(s) reviewed the clinical health record of one resident, observed the resident, observed resident care practices and staff interactions with residents.

The following Inspection Protocols were used during this inspection:

Contenance Care and Bowel Management

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

<b>Legend</b> WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	<b>Legendé</b> 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 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 :**

The Administrator received a verbal report from a family member alleging that an identified resident was verbally abused by a Personal Support Worker. The Administrator immediately investigated the allegations. The licensee failed to report the results of the investigation to the Director. [s.23(2)] A report was submitted on November 23, 2011 at the request of the inspector.

**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 licensee reports to the Director the results of every investigation of every alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.**

**WN #2: 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 subsections:**

**s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).**

**Findings/Faits saillants :**

The Administrator received a verbal report from a family member alleging that an identified resident was verbally abused by a Personal Support Worker. The Administrator immediately investigated the allegations. The licensee failed to make a report to the Director within 10 days of becoming aware of the alleged incident.[r.104(2)] A report was submitted on November 23, 2011 at the request of the inspector.



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**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 report is submitted to the Director within 10 days of becoming aware of an alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.***

Issued on this 30th day of November, 2011

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

*Lyndee Duchesne for  
Pat Powers.*