

**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
Feb 20, 2020	2020_786744_0005	021680-19, 000341-20	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 Timmins
62 St-Jean Avenue TIMMINS ON P4R 0A6

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

STEVEN NACCARATO (744), TIFFANY BOUCHER (543)

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 10-14, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

- One intake related to a critical incident that the home submitted to the Director regarding improper care of a resident;**
- One intake related to a critical incident that the home submitted to the Director regarding a fall of a resident resulting in an injury.**

Complaint inspection #2020_786744_0004 was conducted concurrently with this Critical Incident System (CIS) inspection.

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

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A critical incident (CI) report was submitted to the Director on a specified date, related to resident #004 being left unattended in an unsafe manner.

Inspector #543 reviewed resident #004's care plan which identified that the resident required assistance from a specified number of staff members, when being transferred.

The Inspector reviewed the resident's progress notes. A progress note dated on a specified date, indicated that the resident was left unattended in an unsafe manner.

Inspector #543 reviewed the home's internal investigation notes, which identified a note dated on a specified date; indicating that PSW #106 stated that resident #004 was left unattended in an unsafe manner for a specified period of time.

Inspector #543 interviewed PSW #013 and #105, who indicated that when transferring a resident, at no time should the resident be left unattended.

Inspector #543 interviewed RPN #104 who verified that no resident should be left unattended when being transferred in a specific manner.

The Inspector interviewed the DOC, related to resident #004 being left unattended in an unsafe manner on a specified date. They verified that the resident should never have been left unattended during the transfer. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 20th day of February, 2020

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

Original report signed by the inspector.