

**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
Jan 20, 2022	2022_895609_0002	015802-21	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 Timmins
62 St-Jean Avenue Timmins ON P4R 0A6

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

KAREN HILL (704609)

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): January 4 - 7, 2022.

The following complaint was inspected upon during the Complaint inspection:

- one intake, related to a complaint submitted regarding improper care and negligence.

A Critical Incident System (CIS) Inspection #2022_895609_0001, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Infection Prevention and Control (IPAC) Lead, the Porcupine District Public Health Unit, Screener, Helping Hands, Dietary Aide, Physiotherapy Assistant, Housekeeping staff, and residents.

The Inspector also conducted walkabouts of resident home areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, observed infection control practices, reviewed relevant health care records, relevant staffing schedules and training records, as well as relevant licensee's policies and procedures.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management**

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

1 WN(s)

0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:

- 1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
- 2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
- 3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for a resident, specifically a treatment.

The electronic documentation records for the resident from an identified time frame, indicated that on three occasions, there was no documentation related to the provision of a treatment required for the resident.

A staff member indicated that the provision of the treatment required should have been documented.

The home's failure to ensure that documentation of the provision of a treatment for the resident, may have put the resident at risk by delaying communication about any changes or concerns related to the resident's condition. [s. 6. (9) 1.]

Issued on this 25th day of January, 2022

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

Original report signed by the inspector.