



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

**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**

Sudbury Service Area Office  
159 Cedar Street Suite 403  
SUDBURY ON P3E 6A5  
Telephone: (705) 564-3130  
Facsimile: (705) 564-3133

Bureau régional de services de  
Sudbury  
159 rue Cedar Bureau 403  
SUDBURY ON P3E 6A5  
Téléphone: (705) 564-3130  
Télécopieur: (705) 564-3133

**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 17, 2016	2016_320612_0004	026094-15	Follow up

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**Licensee/Titulaire de permis**

EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE YORK  
333 YORK STREET SUDBURY ON P3E 5J3

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

SARAH CHARETTE (612), TIFFANY BOUCHER (543)

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

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**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): January 25- 29 and February 1, 2016**

**During the course of the inspection, the inspector(s) spoke with The Senior Administrator, The Administrator, The Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Environmental Services Manager, Admissions Coordinator, Residents and their family members.**

**The inspectors conducted a daily walk through of common areas, observed the provision of care to residents, observed staff to resident interactions, reviewed various policies and procedures, reviewed complaint records, and reviewed residents' clinical records.**

**The following Inspection Protocols were used during this inspection:  
Personal Support Services  
Safe and Secure Home**

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

**1 WN(s)  
0 VPC(s)  
1 CO(s)  
0 DR(s)  
0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**

**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #003	2015_391603_0024		612
O.Reg 79/10 s. 20. (1)	CO #004	2015_391603_0024		612
O.Reg 79/10 s. 20. (2)	CO #005	2015_391603_0024		612
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_391603_0024		543
LTCHA, 2007 S.O. 2007, c.8 s. 6. (5)	CO #002	2015_391603_0024		543

### NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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



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**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. (7) The licensee shall ensure that the care set out in the plan of care is  
provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #612 observed resident #016 during the dining service on January 27, 2016. The inspector observed PSW #122 feeding resident #016 and that the resident's wheelchair was tilted at a specific angle. PSW #122 stated that the resident was to be fed at the specific angle the Inspector had observed.

A review of resident #016's plan of care revealed that the resident's chair was to be at a different angle while staff were feeding the resident.

An interview with PSW #123, RN #124 and the Director of Care confirmed that resident #016 was to be fed as per the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #543 reviewed a Critical Incident report which described that in July, 2015, during the night shift, resident #001 was found on the floor in their room. RN #111 instructed PSW #112 and RPN #113 to assist them to transfer the resident back to bed. The RN began the transfer before the RPN and PSW could refuse to transfer the resident manually.

Inspector #543 reviewed resident #001's plan of care (in place at the time of the incident) which indicated that the resident required the total assistance of two staff members for transferring with the use of a mechanical lift.

Inspector #543 interviewed the Director of Care, who confirmed that the resident was not transferred via a mechanical lift as was indicated in their plan of care.

No further action will be taken in regards to this non-compliance as the incident occurred prior to the compliance date for Compliance Order #006 which was December 2, 2015, from inspection #2015\_391603\_0024(A3). [s. 6. (7)]



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***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 22nd day of February, 2016**

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

**Original report signed by the inspector.**



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
des Soins de longue durée

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007, S.O. 2007, c.8*

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

**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**

**Public Copy/Copie du public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** SARAH CHARETTE (612), TIFFANY BOUCHER (543)

**Inspection No. /**

**No de l'inspection :** 2016\_320612\_0004

**Log No. /**

**Registre no:** 026094-15

**Type of Inspection /**

**Genre**

Follow up

**d'inspection:**

**Report Date(s) /**

**Date(s) du Rapport :** Feb 17, 2016

**Licensee /**

**Titulaire de permis :**

EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST, SUITE 700,  
MARKHAM, ON, L3R-9W2

**LTC Home /**

**Foyer de SLD :**

EXTENDICARE YORK  
333 YORK STREET, SUDBURY, ON, P3E-5J3

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Tracy Lamirande

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To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
des Soins de longue durée**

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
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**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order /**

**Lien vers ordre  
existant:** 2015\_391603\_0024, CO #006;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee shall develop and implement the following:

1. A process to ensure that the care set out in the plan of care for all residents, and specifically resident #016, is provided as specified in the plan.
2. An auditing process that will identify when staff are not providing care as specified in the plan of care, so that corrective action can be taken.
3. A multidisciplinary process to ensure clear communication between RNs, RPNs and PSWs related to the requirements in residents' plans of care.

**Grounds / Motifs :**





**Ministry of Health and  
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**Ministère de la Santé et  
des Soins de longue durée**

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #612 observed resident #016 during the dining service on January 27, 2016. The inspector observed PSW #122 feeding resident #016 and that the resident's wheelchair was tilted at a specific angle. PSW #122 stated that the resident was to be fed at the specific angle the Inspector had observed .

A review of resident #016's plan of care revealed that the resident's chair was to be at a different angle while staff were feeding the resident.

An interview with PSW #123, RN #124 and the Director of Care confirmed that resident #016 was to be fed as per the plan of care.

The Inspector was following up on compliance order #006 issued during inspection #2015\_391603\_0024(A3). The decision to reissue this compliance order was based on the scope, which was isolated and the severity, which indicates a potential for actual harm to the resident. LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as a VPC during Inspection #2014\_331595\_0010, a CO during Inspection #2013\_138151\_0008 and a VPC during Inspection #2013\_140158\_0001. (612)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2016**



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**REVIEW/APPEAL INFORMATION**

**TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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de l'article 154 de la *Loi de 2007 sur les foyers  
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 17th day of February, 2016**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Sarah Charette

**Service Area Office /**

**Bureau régional de services :** Sudbury Service Area Office