



**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**

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## 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>
Mar 1, 2016	2016_264609_0005	027735-15	Critical Incident System

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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 TIMMINS  
62 St-Jean Avenue TIMMINS ON P4R 0A6

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

CHAD CAMPS (609)

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## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): January 18, 19, 20, 21, 25, 26, 27, 28, 29, 2016**

**This inspection was completed related to two Critical Incidents submitted to the Director related to allegations of staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator and two Registered Nurses (RN).**

**The inspector(s) also reviewed internal investigations, clinical records, plans of care, components of employee human resource files, policies and procedures and training logs.**

**Ad-hoc notes were used during this inspection.**

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

**2 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 24. Reporting certain matters to Director**



**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CI) was submitted to the Director that indicated a staff member witnessed abuse of a resident by another staff member.

An interview with the DOC revealed the staff member who witnessed the abuse left a note for the DOC in their mailbox which resulted in a two day gap in the DOC becoming aware.

A review of the home's policy titled "Resident Abuse- Staff to Resident" last revised September 2015 indicated staff were to immediately report (verbally) any suspected or witnessed abuse to the Administrator, DOC or their designate.

An interview with the DOC confirmed that it was the expectation of the home that any staff member who suspected or the witnessed abuse of a resident would immediately report the information to the Administrator or DOC, that in the case of witnessed abuse, the staff member did not immediately report the allegations of abuse and should have. [s. 24. (1) 1.]



***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 person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**

- 1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
- 2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
- 3. Behaviour management. 2007, c. 8, s. 76. (7).**
- 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
- 5. Palliative care. 2007, c. 8, s. 76. (7).**
- 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that that all staff who provided direct care to residents, received training relating to abuse recognition and prevention annually.

A Critical Incident Report was submitted to the Director which made allegations of potential staff to resident abuse.

Interviews with registered staff revealed that they were unable to identify allegations of verbal abuse, their roles or the procedure for responding to allegations of abuse.

An interview with the Administrator revealed that all staff were to have completed two online learning modules in 2015 related to the prevention of abuse of residents.

A review of the training logs for 2015 revealed two of the eight or 25 per cent of the full time RN staff did not complete the two required retraining modules related to the prevention of abuse of residents.

An interview with the DOC confirmed that it was the expectation of the home that all RNs were to have completed in 2015, the required retraining in the prevention of abuse of residents, that in the case the of 25 per cent of the full time RN workforce who did not complete the 2015 retraining, the home was not in compliance with the Act and should have been. [s. 76. (7) 1.]

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**Issued on this 7th day of March, 2016**

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

**Original report signed by the inspector.**