



**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**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 19, 2016	2016_391603_0018	007669-16	Follow up

Licensee/Titulaire de permis

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

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

SYLVIE LAVICTOIRE (603), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): July 25-28, 2016.

This Follow up inspection is related to Compliance Orders (CO) #001 and #002 issued from inspection #2016_264609_0002 and CO #003 issued from inspection #2015_336620_0008.

A Complaint Inspection #2016_391603_0016 and a Critical Incident Inspection # 2016_391603_0017 were conducted concurrently.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Staff, Behavioral Support Ontario (BSO) Staff, Office Manager, Residents, and Family Members.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Skin and Wound Care
Sufficient Staffing**

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

- 2 WN(s)**
- 0 VPC(s)**
- 2 CO(s)**
- 2 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. 15. (2)	CO #003	2015_336620_0008		603

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>Legendé</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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

During inspection #2016_264609_0002, the home was issued a Compliance Order (CO) #001 whereby they were to ensure that every member of the home's direct care staff completed retraining on the home's skin and wound care policies, procedures and responsibilities.

Inspector #603 requested and reviewed the home's training records for CO #001. The "Wound Care, Weekly Wound Assessment, Wound Care Procedure Form", dated March 29-April, 2016, indicated that only registered staff (RNs and RPNs) had been trained.

Inspector #603 interviewed the Director of Care (DOC) who explained that the home did not retrain all direct care staff on the home's skin and wound care policies, procedures, and responsibilities. The DOC explained that the home only retrained the registered nurses (RNs) and registered practical nurses (RPNs) as they were the staff dealing with skin and wound care. The DOC confirmed that PSWs conducted skin assessments and reported any findings to the RPNs or RNs. [s. 6. (4)]



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Additional Required Actions:

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for
further action by the Director.***

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8.
Nursing and personal support services**

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :



1. The licensee has failed to ensure that there was at least one registered nurse (RN) who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement.

During a previous inspection #2016_264609_0002, CO #002 was issued to the home. The home was to review and revise the staffing plan to ensure that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

Inspector #638 reviewed the home's "Staffing Procedure", revised May 4, 2016, which directed staff in charge of filling an RN shift, to offer the shift to all RPNs available, once the RN list had been exhausted. The staffing procedure indicated that if the shift was not replaced by an RN, then the home would work short, and the RPN would complete the RN duties. At that time, the Administrator or the DOC were to be notified, with no indication of their roles.

Inspector #638 interviewed the DOC who confirmed that the "Staffing Procedure" was not clear should the steps be followed as laid out within the procedure. The DOC also explained that the roles of the Administrator or the DOC, when there was no RN available, were not written within the "Staffing Procedure" in order to ensure that there would always be an RN within the home as laid out within the legislation. [s. 8. (3)]

Additional Required Actions:

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 002 – The above written notification is also being referred to the Director for further action by the Director.***



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

Issued on this 20th day of September, 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

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SYLVIE LAVICTOIRE (603), RYAN GOODMURPHY
(638)

Inspection No. /

No de l'inspection : 2016_391603_0018

Log No. /

Registre no: 007669-16

Type of Inspection /

Genre

Follow up

d'inspection:

Report Date(s) /

Date(s) du Rapport : Sep 19, 2016

Licensee /

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

LTC Home /

Foyer de SLD : EXTENDICARE TIMMINS
62 St-Jean Avenue, TIMMINS, ON, P4R-0A6

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Kelly Roy

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**

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

**Ministère de la Santé et
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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



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*

Order # /

Ordre no : 001

Order Type /

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

Linked to Existing Order /

**Lien vers ordre
existant:** 2016_264609_0002, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that every member of the home's direct care staff, including all Personal Support Workers, are retrained on the home's skin and wound care policies, procedures, and responsibilities.

Grounds / Motifs :

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*

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

During inspection #2016_264609_0002, the home was issued a Compliance Order (CO) #001 whereby they were to ensure that every member of the home's direct care staff completed retraining on the home's skin and wound care policies, procedures and responsibilities.

Inspector #603 requested and reviewed the home's training records for CO #001. The "Wound Care, Weekly Wound Assessment, Wound Care Procedure Form", dated March 29-April, 2016, indicated that only registered staff (RNs and RPNs) had been trained.

Inspector #603 interviewed the Director of Care (DOC) who explained that the home did not retrain all direct care staff on the home's skin and wound care policies, procedures, and responsibilities. The DOC explained that the home only retrained the registered nurses (RNs) and registered practical nurses (RPNs) as they were the staff dealing with skin and wound care. The DOC confirmed that PSWs conducted skin assessments and reported any findings to the RPNs or RNs.

LTCHA, 2007 S.O. 2007, s. 6. (4) was issued previously as CO during Inspection #2015_336620_0008 and a CO during Inspection #2016_264609_0002.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous compliance orders, NC continues with this area of the legislation. (603)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2016



**Ministry of Health and
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**Ministère de la Santé et
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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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*

Order # /
Ordre no : 002 **Order Type /**
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre 2016_264609_0002, CO #002;
existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall review and revise the staffing plan to ensure that at least one RN who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse (RN) who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement.

During a previous inspection #2016_264609_0002, CO #002 was issued to the home. The home was to review and revise the staffing plan to ensure that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

Inspector #638 reviewed the home's "Staffing Procedure", revised May 4, 2016, which directed staff in charge of filling an RN shift, to offer the shift to all RPNs available, once the RN list had been exhausted. The staffing procedure indicated that if the shift was not replaced by an RN, then the home would work short, and the RPN would complete the RN duties. At that time, the Administrator or the DOC were to be notified, with no indication of their roles.

Inspector #638 interviewed the DOC who confirmed that the "Staffing Procedure" was not clear should the steps be followed as laid out within the procedure. The DOC also explained that the roles of the Administrator or the DOC, when there was no RN available, were not written within the "Staffing Procedure" in order to ensure that there would always be an RN within the home as laid out within the legislation.

LTCHA, 2007 S.O. 2007, s. 8. (3) was issued previously as a CO during Inspection #2015_336620_0008 and a CO during Inspection #2016_264609_0002.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous compliance orders, NC continues with this area of the legislation.

(638)



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section 154 of the *Long-Term Care
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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

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Oct 18, 2016



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



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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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e 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
de soins de longue durée, L.O. 2007, chap. 8*

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
Inspection de soins de longue durée
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.

Issued on this 19th day of September, 2016

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** Sylvie Lavictoire

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