Ontario

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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 14, 2014	2014_140158_0011	S-000251-14, S-000038-14	Critical Incident System

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

KELLY-JEAN SCHIENBEIN (158)

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): June 23, 2014

Logs # S-000251-14 and S-000038-14 were reviewed during this Critical Incident Inspection.

During the course of the inspection, the inspector(s) spoke with spoke with the Administrator, Assistant Director of Nursing (ADON), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed staff to resident interactions and care and reviewed the home's policies and procedures related to Abuse.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the results of the abuse or neglect investigation were reported to the Director. Staff # 100 was allegedly rude and refused to provide money to resident # 01 from resident # 01's trust account. The Critical Incident was reported to the Director and identified that further investigation, by the Corporate office, into the incident would be done. On June 23, 2014, the Administrator stated to the Inspector that there is a specific performance improvement plan in place for staff # 100 and that the resident has accepted staff #100 apology. The Critical Incident reported to the Director was not updated to reflect the results of this investigation. [s. 23. (2)]

WN #2: 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 person who had reasonable grounds to suspect that abuse of a resident by anyone occurred did not immediately report the suspicion and the information upon which it was based to the Director.
A Critical Incident identified that staff # 100 was allegedly rude and refused to give resident # 01 money from the resident # 01's trust account. Resident # 01 verbally informed the Director of Care of the incident. An investigation was started, however, the alleged abuse was not reported to the Director until five days later.
The licensee failed to ensure that the alleged incident of resident abuse was immediately reported to the Director. [s. 24. (1)]

Issued on this 14th day of July, 2014

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