



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

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

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**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
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**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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2015	2015_280541_0010	O-001521-15	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 COBOURG
130 NEW DENSMORE ROAD COBOURG ON K9A 5W2

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

AMBER MOASE (541)

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): March 17-20 and March 27, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, Personal Support Workers and a Resident.

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

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

2 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>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. 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On a specified date and time, Registered Nurse (RN) #S100 was informed by Resident #1 that staff member #S109 had yelled at Resident #1 and was mean. RN documented on the Investigation Observation Form that Resident #1 appeared anxious and three times throughout the day had asked staff to not say anything as Resident #1 was unsure what the staff member would do. RN #S100 stated to Inspector #541 that upon becoming aware of the incident she had reasonable grounds suspect this was an allegation of verbal abuse. RN #S100 then reported this allegation to the DOC and Administrator at morning report that same morning.

The Administrator and the DOC stated to Inspector #541 during an interview on specified dates that upon becoming aware of the incident, they had reasonable grounds to suspect verbal abuse had occurred. The DOC stated an investigation into this incident began immediately upon becoming aware of the incident.

The Director was not notified of this incident of alleged verbal abuse until the day following the incident. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents



Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On a specified date and time, Resident #1 informed Registered Nurse (RN) #S100 that Staff member #S109 had yelled at him/her and was mean. RN #S100 documented on the Investigation Observation Form upon becoming aware of the incident that Resident #1 appeared anxious and three times throughout the day had asked staff to not say anything as Resident #1 was unsure what the staff member would do. RN #S100 stated during an interview with Inspector #541 on March 18, 2015 that she immediately had reasonable grounds to suspect this was an allegation of verbal abuse.

The SDM for Resident #1 was not immediately notified as they were not called until the following day. [s. 97. (1) (a)]



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Issued on this 1st day of May, 2015

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

Original report signed by the inspector.