



**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  
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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**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 24, 2013	2013_179103_0004	O-002115-12	Critical Incident System

**Licensee/Titulaire de permis**

EXTENDICARE CENTRAL ONTARIO INC  
82 Park Road North, OSHAWA, ON, L1J-4L1

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

EXTENDICARE OSHAWA  
82 PARK ROAD NORTH, OSHAWA, ON, L1J-4L1

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

DARLENE MURPHY (103)

**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): January 23 and 24, 2013

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

During the course of the inspection, the inspector(s) reviewed a resident health care record, and reviewed the home's abuse policy.

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**

<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. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**



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The licensee has failed to comply with LTCHA, 2007 s. 20 (1) whereby an incident of alleged abuse was not immediately reported in accordance with the home's abuse policy.

On an identified date, an alleged incident of resident abuse was reported by staff to the charge nurse.

The home policy titled, "Resident Abuse and Neglect, #OPER-02-02-04" states under the policy statement that all staff is responsible to ensure that they understand and comply fully with the Resident Abuse and Neglect policy and procedures. "Procedure: Immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or designate."

The incident of alleged abuse was not reported to the Director of Care until the following day.

The staff member failed to comply with the home policy on abuse by failing to immediately report the suspected abuse of a resident to the Administrator or the Director of Care. [s. 20. (1)]

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**Issued on this 24th day of January, 2013**

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

A handwritten signature in cursive script that reads "Darlene Murphy".