



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  
prévus le Loi de 2007 les  
foyers de soins de longue

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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| Date(s) of inspection/Date(s) de l'inspection     | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---------------------------------------------------|-----------------------------------|---------------------------------------|
| Aug 29, 30, Sep 9, <sup>La</sup> 21, Oct 11, 2011 | 2011_026147_0021                  | Critical Incident                     |

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 HALTON HILLS  
9 Lindsay Court, Georgetown, ON, L7G-6G9

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator and Acting Director of Care related to Critical Incident Log #H-001474-11

During the course of the inspection, the inspector(s) Reviewed resident's clinical chart, reviewed home's policy and procedure related to Prevention of abuse, observed care, toured the home, and observed staff in routine duties.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend                                                                                                                                                                                                                                                                  | Legendé                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order                                                                                                                     | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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. 19. Duty to protect**  
**Specifically failed to comply with the following subsections:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. A resident's family reported to the home in 2011 regarding overhearing a Personal Support Worker (PSW) verbally abusing residents on the unit. The home conducted an internal investigation into the matter and confirmed the verbal abuse by the PSW towards other resident's on the unit. The home failed to protect residents from abuse by the staff in the home.

**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 the licensee shall protect all residents from abuse by anyone, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**  
**Specifically failed to comply with the following subsections:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**

**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.**

**2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.**

**3. A response shall be made to the person who made the complaint, indicating,**

**i. what the licensee has done to resolve the complaint, or**

**ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**



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1. The home received two letters of complaint from an identified resident's family related to observation of verbal abuse by a Personal Support Worker towards other resident's on the unit. The home initiated an internal investigation into the matter, however failed to provide a written acknowledgement within 10 business days of receipt to the complainant.

***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 all complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 days of receipt of the the complaint, to be implemented voluntarily.***

Issued on this 21st day of September, 2011

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