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 prévue le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 22, 2017;	2017_463616_0009 (A1)	028252-16, 034300-16	Complaint

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 FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

JENNIFER KOSS (616) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension to the compliance date.

Issued on this 22 day of September 2017 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 les foyers de soins de longue durée

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281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

JENNIFER KOSS (616) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 26 to 30, 2017

This complaint inspection was related to:

- two complaints related to the lack of personal care of a resident and missing personal items.

In addition, a Follow Up and Critical Incident System Inspection were conducted concurrently. Please refer to Follow Up Inspection #2017_463616_0010 and Critical Incident System Inspection #2017_509617_0015 for details.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Falls Prevention

Medication

Pain

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Two complaints were received by the Director on a date in September and a date in December 2016, regarding the lack of personal care of resident #002.

During Inspector #616's interview with the complainant on a date in June 2017, they reported that resident #002 had a fall in May 2017, and sustained injuries. The complainant verified resident #002's ability to use a safety device when needed if the device was within their reach and they were aware that resident #002's care plan identified a specific instruction related to falls prevention.

The Inspector reviewed the associated Critical Incident System (CIS) report that the home had submitted to the Director on a date in May 2017, related to resident #002's fall a few days prior. According to the CIS report, PSW #104 heard resident #002's voice and found them on the floor. The resident had diagnosed injuries related to the fall.

In the home's investigation notes, RN #102 had reported to the DOC that the resident's safety device had not been accessible at the time of their fall. PSW #104 who discovered resident #002 on the floor after the resident's voice was heard, had reported that they were unavailable at the time of the resident's fall.

During an interview with the DOC, they confirmed that on the day of the incident, specific interventions instruction for resident #002 had not been followed prior to their fall.

Resident #002 was not available for interview or observations during the inspection.

During separate interviews with PSW #105 and RPN #106 they informed the Inspector that they were each aware that the resident used the safety device when needed and that staff ensured the device was within the resident's reach. They both stated they were aware of the resident's specific interventions related to falls prevention.

The resident's care plans in effect at the time of the fall was reviewed by the Inspector. The care plan identified specific interventions related to falls preventions as well as instructions regarding the safety device.

The Inspector reviewed a physician's order regarding this specific intervention for resident #002.

During the Inspector's interview with the DOC on June 28, 2017, they

acknowledged that the care provided by staff on a particular day in May 2017, was not as per resident #002's plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Two complaints were received by the Director on a date in September and on a date in December 2016, regarding the lack of personal care of resident #002.

During Inspector #616's interview with the complainant on a date in June 2017, they reported that resident #002 had physician's orders for two specific medications. The complainant stated they had been notified by the home's staff a week after the fact, that the resident had not received one of the two medications as ordered.

Resident #002 was not available for interview or observations at the time of the inspection.

The Inspector conducted a record review related to the reported missed medication.

A record was located for the missed medication that included its purpose, the dose, the route of administration and the duration to have been used with an identified end date. Another record indicated that the medication had been administered as ordered.

However, the Inspector found a different record where RN #122 had been made aware by RPN # 106 that 69 per cent of the specific medication was remaining out of total number of tablets sent from pharmacy. They identified that the resident's medication was to have been completed on a certain date. The RN had also documented that reporting RPN #106 had completed on an internal form related to the incident.

During the Inspector's interview with Assistant Director of Care #110 they stated that they were aware of resident #002 not having received this specific medication as they had reviewed the internal form and followed up with staff. They confirmed that this particular medication prescribed for resident #002 had not been administered as ordered. [s. 131. (2)]

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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 22 day of September 2017 (A1)

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

Original report signed by the inspector.

Ontario

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER KOSS (616) - (A1)

Inspection No. / No de l'inspection : 2017_463616_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 028252-16, 034300-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 22, 2017;(A1)

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

LTC Home / Foyer de SLD :
EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON,
P3A-5K4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Laura Halloran

Ontario

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

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that for every resident at risk for falls, staff provide care as specified in each resident's plan of care, including falls prevention for resident #002.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Two complaints were received by the Director on a date in September and a date in December 2016, regarding the lack of personal care of resident #002.

During Inspector #616's interview with the complainant on a date in June 2017, they reported that resident #002 had a fall in May 2017, and sustained injuries. The complainant verified resident #002's ability to use a safety device when needed if the device was within their reach and they were aware that resident #002's care plan identified a specific instruction related to falls prevention.

The Inspector reviewed the associated Critical Incident System (CIS) report that the home had submitted to the Director on a date in May 2017, related to resident #002's fall a few days prior. According to the CIS report, PSW #104 heard resident #002's voice and found them on the floor. The resident had diagnosed injuries related to the

fall.

In the home's investigation notes, RN #102 had reported to the DOC that the resident's safety device had not been accessible at the time of their fall. PSW #104 who discovered resident #002 on the floor after the resident's voice was heard, had reported that they were unavailable at the time of the resident's fall.

During an interview with the DOC, they confirmed that on the day of the incident, specific interventions for resident #002 had not been followed prior to their fall.

Resident #002 was not available for interview or observations during the inspection.

During separate interviews with PSW #105 and RPN #106 they informed the Inspector that they were each aware that the resident used the safety device when needed and that staff ensured the device was within the resident's reach. They both stated they were aware of the resident's specific interventions related to falls prevention.

The resident's care plans in effect at the time of the fall was reviewed by the Inspector. The care plan identified specific interventions related to falls preventions as well as instructions regarding the safety device.

The Inspector reviewed a physician's order regarding this specific intervention for resident #002.

During the Inspector's interview with the DOC on June 28, 2017, they acknowledged that the care provided by staff on a particular day in May 2017, was not as per resident #002's plan of care.

The decision to issue a Compliance Order (CO) was determined by the scope, although isolated, the severity of not following the plan of care was actual harm to resident #002. The home has a history of non-compliance in this area of the legislation as follows:

- a VPC during CIS inspection #2016_282543_0010 related to nutrition and hydration;
- a VPC during CO inspection #2015_320612_0025 related to nutrition and hydration; and

- a VPC during RQI inspection #2015_282543_0014 related to falls and minimizing of restraining.
(616)

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

Nov 10, 2017(A1)

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

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

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

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.

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, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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.

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
Toronto ON M5S 2B1
Télécopieur : 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 22 day of September 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JENNIFER KOSS

Service Area Office /
Bureau régional de services : Sudbury