Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2020	2020_828759_0003	024101-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

KEARA CRONIN (759), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 14-17 and 20, 2020.

The following intake was inspected during this complaint inspection:

- One complaint submitted to the Director regarding 24-hour Registered Nurse (RN) coverage, falls preventions interventions and mobility devices.

Please note this inspection was completed concurrently with a Critical Incident inspection #2020_828759_0002.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care(s), Physiotherapists, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The Inspectors conducted daily observations of the provision of care that was provided to the residents, reviewed relevant health care records, policies and procedures, and staffing schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
0 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #002 was based on

an assessment of the resident.

A complaint was submitted to the Director. The complainant expressed concerns regarding the removal of resident #002's mobility aid from their room.

Inspector #759 reviewed resident #002's electronic health care records in Point Click Care (PCC) and identified a progress note written on a specified day, by Registered Nurse (RN) #123. The progress note indicated that the resident's family member removed the resident's mobility aid and a referral was sent to restorative care to reassess the resident's mobility needs.

Inspector #759 identified a referral titled "Referral - Restorative Nursing" created on the same day as the progress note, which indicated that resident #002's family member felt that the resident had a change in condition and should not continue using the mobility aid. It further stated that they wanted resident #002 reassessed.

During an interview with Inspector #759, Personal Support Worker (PSW) #111 indicated that resident #002 had a change in condition and that the family member removed the mobility aid as they were worried about their mobility.

Inspector #759 interviewed Registered Practical Nurse (RPN) #116, who indicated that the family member wanted resident #002 to use a different mobility aid.

Inspector #759 further reviewed resident #002's electronic health care records, and identified a quarterly assessment titled "Rehab - Physiotherapy Assessment V1" completed on a specific date. The assessment indicated that resident #002 utilized two different mobility aids. It stated that there were "no changes with mobility [and] transfer" and that resident #002 completed a specified exercise. Inspector #759 identified this assessment as the most recent assessment that assessed resident #002's mobility aids.

Inspector #759 identified a progress note written by Physiotherapist (PT) #118 on a specified date, which indicated that one of resident #002's family members approached them and inquired if they could mobilize the resident using a specified intervention. PT #118 responded that they had to assess the resident's mobility.

Inspector #759 interviewed PT #118 on a specified date. They confirmed that the assessment had not yet been completed to assess resident #002's mobility.

The licensee has failed to ensure resident #002's plan of care was based on an assessment of the resident. There was was no assessment completed of resident #002's mobility status and use of mobility aids when resident #002's mobility aid was removed. [s. 6. (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 the plan of care for resident #002 is based on an assessment of the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident to staff communication and response system was easily seen and accessed by resident #003.

On a specified date, Inspector #759 observed resident #003 in their room near the end of their bed. Inspector #759 noted the call bell to be out reach for the resident; it was clipped to the call bell cord where the call bell was plugged into the wall above the head of the bed.

Inspector #759 interviewed PSW #126 regarding resident #003’s falls interventions. They indicated that resident #003 had a specified intervention regarding their call bell use.

Inspector #759 reviewed resident #003’s current care plan. Inspector #759 noted a specified intervention for resident #003's call bell use.

Inspector #759 presented resident #003’s call bell to PSW #126, they confirmed the call bell was not in reach for the resident. [s. 17. (1) (a)]

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 the resident to staff communication and response system is easily seen and accessible to resident #003, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff, who was always on duty and present in the home.

A complaint was submitted to the Director, regarding the use of an agency RN.

Inspector #759 reviewed the document titled “Staffing Plan for Extendicare Falconbridge” last reviewed October 2015. The document indicated the number of RNs per shift. It also stated “there must be a minimum of [one] RN in the building at all times”.

Inspector #759 interviewed RN #117 and they indicated that there were times the home utilized an agency RN and they were the only RN in the home, they were unable to recall when.

Inspector #759 requested to review the RN staffing schedules from October 2019 to January 2020, in specific Inspector #759 requested documents to confirm when the home utilized an agency RN during this time frame. Inspector #759 identified that the home utilized an agency RN for six days.

Inspector #759 reviewed the schedules on these dates and identified that an agency RN was the sole RN present in the home on on four days during specific shifts.

Inspector #759 interviewed the Director of Care (DOC), they confirmed they were aware that an agency RN was the sole RN in the home on four specific dates. They further stated they had no staff to cover the shifts.

The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff, for four shifts. [s. 8. (3)]

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.