Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
Mar 17, 2021	2021_822613_0005	020985-20, 000223-21, 000242-21, 000318-21, 001646-21, 002814-21	Critical Incident System

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

LISA MOORE (613), JENNIFER LAURICELLA (542)

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): March 2-5, 2021.

The following intake was inspected during this Inspection:

Three Critical Incident (CI) reports that were submitted to the Director regarding regarding a resident fall resulting with an injury and transfer to the hospital;

One CI report regarding suspected staff to resident abuse;

One CI report regarding resident to resident abuse; and

One CI report regarding an unexpected death.

A concurrent Complaint Inspection #2021_822613_0004 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Directors of Care (ADOC), Restorative Care, Housekeeping staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, and internal investigation files, staff personal files, and reviewed relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

Specifically, staff did not comply with the licensee's Falls Management and Prevention Program policy.

The licensee's policy identified that for post fall management the care staff was to report any incidents of a resident found on the floor to the nurse, transfer the resident only after the nurse had assessed the resident and approved the transfer and that the nurse would hold a post-fall huddle and complete a post falls assessment.

A review of the home's investigation file identified that a resident was transferred off the floor by two PSWs without the resident being assessed and the transfer being approved by a nurse.

A review of the resident's plan of care indicated that a post falls assessment and a post fall huddle had not been completed by a RPN.

The Director of Care (DOC) verified that the PSW's should not have lifted the resident off the floor and that the RPN had not completed a post falls assessment or a post fall huddle. The DOC confirmed that staff did not comply with the licensee's Fall Management and Prevention Policy.

Sources: CIS report; the home's internal investigation notes; the licensee's Falls Management and Prevention Program; the resident's plan of care and interviews with the DOC and other staff. [s. 8. (1) (b)]

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to include material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: a description of the individuals involved in the incident, including, names of any staff members or other person who were present at or discovered the incident.

A review of a Critical Incident (CIS) report submitted to the Director regarding an allegation of abuse by staff towards a resident, did not identify the names of any staff members or other person who were present or discovered the incident.

The Director of Care (DOC) verified that the CIS report did not identify any staff members names.

Sources: CIS report; the home’s internal investigation notes; and an interview with the DOC.

2. A CIS report was submitted to the Director, regarding an incident of abuse towards a resident by another resident. The CIS report indicated that a PSW witnessed the incident. The CIS report did not identify the names of any staff members or other person who were present or discovered the incident.

The Director of Care (DOC) verified that the CIS report did not identify any staff members names.

Sources: CIS report; the home’s internal investigation notes: and an interview with the DOC. [s. 104. (1) 2. ii.]

Issued on this 18th day of March, 2021

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

Original report signed by the inspector.