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
Jun 17, 2021	2021_805638_0008	003571-21, 005949-21, 007759-21, 007857-21	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

RYAN GOODMURPHY (638), AMY GEAUVREAU (642)

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): May 31 - June 4 and June 7 - 8, 2021.

The following intakes were inspected upon during this Critical Incident System inspection;
-Two logs related to incidents of resident to resident physical abuse;
-One log related to staff to resident improper care; and
-One log related to an unwitnessed fall resulting in an injury.

Complaint inspection #2021_805638_0009 was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Support Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Assistants, residents and their families.

The Inspector(s) also conducted daily tours of resident care areas, reviewed relevant health care records, internal investigation notes, policies and procedures, observed staff to resident interactions, the implementation of infection prevention and control practices, as well as the provision of care to residents and services within the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

4 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident set out their planned care related to their risk of falls.

On two separate dates a resident sustained falls. After the second fall, the resident was identified as having a significant change in their status. Upon review of the resident's plan of care the Inspector was unable to determine any focus or interventions to manage the resident's risk of falls. The resident's fall focus and interventions had been resolved in their care plan between the two fall incidents. A PSW identified that staff referenced the resident care plan to know what care needs a resident had including fall interventions.

The Inspector reviewed the resident care plan with the ADOC who identified that the fall focus and interventions to manage their risk should have still been identified within their plan to provide clear direction to staff on how to minimize the resident's risk of falls.

Sources: Resident's care plan; Post fall assessments; Progress notes; Falls Prevention and Management Program, policy RC-15-01-01, dated December 2020; interviews with an ADOC and other staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that a resident plan of care was reviewed and revised when the resident's care needs changed, once they began to demonstrate physically responsive behaviours.

An incident occurred where two residents were physically responsive with each other. One of the residents was noted to have been physically responsive towards other residents on four separate occasions. The resident's plan of care did not identify that the resident had the potential to demonstrate physically responsive behaviours nor did it provide interventions to manage these behaviours. The home's policy identified that the interdisciplinary team was to develop a care plan that addressed the risk of any identified behaviours and provided goals and interventions to promote safe, quality care for every resident. The nurse was required to ensure that the care plan contained information related to each behaviour observed.

An ADOC identified that the resident demonstrated physically responsive behaviours and that registered staff should have updated the plan of care and identified the behaviours once it had been identified so that staff could reference and manage their behaviours.

Sources: Resident's care plan; Progress notes; Minimum Data Set (MDS) assessment; Policy titled Responsive Behaviours RC-17-01-04, reviewed December 2020; interviews with an ADOC and other staff. [s. 6. (10) (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 the resident's plan of care is reviewed and revised, whenever a responsive behaviour is newly identified, to be implemented voluntarily.

WN #2: 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 the Falls Prevention and Management program policy and procedures were complied with, for a resident.

Ontario Regulation 79/10, section 48 (1), requires the home to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Furthermore, Ontario Regulation 79/10, section. 49. (2) requires when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the home's policy and procedure, "Falls Prevention and Management Program", dated December 2020. The program stated staff were to report any incidents of a resident fall immediately to the nurse, and prior to a resident being transferred or assisted to ambulate post-fall, the resident was assessed by a nurse, and transfer the resident post-fall, only after the nurse had assessed the resident and approved the transfer.

A CIS was submitted to the Director which identified a resident had a fall and sustained an injury.

a) The home's investigation documents identified that the PSW had been informed by the resident, that they had fallen, the PSW stated they had transferred the resident back to bed, then informed the RPN about a skin tear and the fall.

The DOC stated that the PSW should not have transferred the resident until after the

nurse assessed the resident and that they had not followed the home's fall policy.

b) The resident's assessments on Point Click Care (PCC) identified there were no fall assessments completed on the date of the fall. A review of the home's investigation document and an interview identified that the PSW had been informed by the resident, that they had fallen. When the home interviewed the RPN, they stated that they had not been informed about the fall and they were only informed about the skin tear.

The RPN stated that they were not informed about the resident's fall or they would have completed the fall assessments, as required for all falls. The RPN stated they were only informed of the skin tear, which they did address. The DOC stated that the RPN should have been informed about the resident's fall, so that they could have completed the fall assessments, as they were required to be done immediately after all falls.

Sources: CIS report; the DOC and ADOC investigation documentation; Risk Management-Injury of Unknown Cause document; Falls Prevention and Management Program, policy RC-15-01-01, dated December 2020; interviews with the DOC and other staff. [s. 8. (1)]

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 staff comply with the home's Fall Prevention and Management program policy and procedures, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing, at a minimum of at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home and every designated cooling area.

As per the amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements, which was sent April 1, 2021, with an effective date of May 15, 2021, Long-Term Care Home's were required to measure and document the air temperature, at a minimum, in certain specified areas in the Long Term Care home at specified intervals.

The Support Services Manager outlined that air temperature was monitored daily in different locations in the home, which included a resident room, each end of the hallway and that they concentrated on areas where residents congregated. The Support Service Manager identified they weren't aware of the changes and they did not obtain readings in all of the required areas outlined in the Ontario Regulation 79/10.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Air Temperature Documentation Record; interviews with the Support Services Manager. [s. 21. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of potential abuse was immediately reported when identified for a resident.

A CIS report was submitted to the Director, which alleged a potential incident of abuse towards a resident, three days earlier. A RPN identified that they had witnessed the potential abuse and had immediately reported the incident.

The DOC stated they had been informed of the incident on the date it occurred, but did not report it until three days later and understood it was reported late. The allegation was unfounded, and there was no risk of harm to the resident.

Sources: CIS report; Abuse policy titled, "Zero Tolerance of Resident Abuse and Neglect Program," last updated June 2020; interviews with the DOC and a RPN. [s. 24. (1)]

Issued on this 18th day of June, 2021

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

Original report signed by the inspector.