

**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**

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

**Public Copy/Copie du rapport public**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jun 17, 2021	2021_805638_0009	003579-21, 004100- 21, 004154-21, 006388-21	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**

RYAN GOODMURPHY (638), AMY GEAUVREAU (642)

---

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

**The following intakes were inspected upon during this Complaint inspection;**

- One log which was related to concerns regarding skin and wound care;**
- One log which was related to concerns regarding personal care as well as nutrition and hydration;**
- One log which was related to concerns regarding personal care as well as skin and wound care; and**
- One log which was related to alleged staff to resident abuse.**

**Critical Incident System inspection #2021\_805638\_0008 was conducted concurrently with this Complaint 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, policies and procedures, observed staff to resident interactions, as well as the provision of care to residents and services within the home.**

**The following Inspection Protocols were used during this inspection:**

**Nutrition and Hydration**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Skin and Wound Care**

**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**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

- s. 50. (2) Every licensee of a long-term care home shall ensure that,**
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
- (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
  - (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
  - (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
  - (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident's wound was reassessed weekly by a member of the registered nursing staff, if clinically indicated.

The resident was ordered to have their areas of altered skin integrity managed daily. No assessments were completed regarding the resident's altered skin integrity during a period of time, when the physician ordered the staff to manage the areas of altered skin integrity. The resident's wounds were only assessed and documented on once during an 11 week period.

A RN identified that wounds were assessed weekly and documented in Point Click Care. The DOC identified that they would have expected to see more assessments completed in that time.

Sources: Resident plan of care; physician orders; progress notes; assessments; Skin and Wound program: Wound Care Management (updated December 2020); interviews with the DOC and other staff. [s. 50. (2) (b) (iv)]

***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 areas of altered skin integrity and any other resident experiencing altered skin integrity is assessed weekly using the home's formalized wound assessment tool, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the PSW complied with the home's policy to promote zero tolerance of abuse during their interaction with a resident.

Verbal abuse is defined within Ontario Regulation 79/10 as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Complaint was submitted to the Director, which alleged that a PSW had abused a resident on a specific date. The resident's progress notes identified that the resident had been interviewed by a RN, who identified that the resident was upset after the incident. Investigation records included a written statement from the PSW, who identified that they had made an inappropriate comment towards the resident. A RPN's written interview stated that they went with the RN to interview the resident and the resident appeared upset, after the incident occurred.

The PSW, who was involved in the incident, stated that they had not physically touched the resident, but got upset when the resident was yelling at them and then made an inappropriate comment to the resident. The DOC stated the PSW had received a notice of discipline for this incident due to the resident feeling intimidated by the PSW's stance, as well as the PSW having admitted to standing their ground while words were exchanged with the resident.

Sources: Complainant interview; Resident progress notes; Internal investigation interview documents; Zero Tolerance of Resident Abuse and Neglect Program (updated June 2020); Interviews with the DOC and other staff. [s. 20. (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.**