Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: December 1, 2023

Inspection Number: 2023-1104-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Falconbridge, Sudbury

Lead Inspector	**Inspector Digital Signature**
Jean-Pierre Nabarra de Bénéjacq (000702)	Jean-Pierre M Nabarra Digitally signed by Jean-Pierre M Nabarra Date: 2023.12.05 15:07:03 -05'00'

Additional Inspector(s)
Barbara Humenjuk (000741)

Present for Inspection
Michelle Berardi (679)
Ryan Goodmurphy (638)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
October 24-27, 2023

The following intakes were completed in this inspection:
- One intake related to a complaint about alleged resident to resident abuse.
- One intake related to a complaint about management of resident behaviors.
- One intake related to critical incident of alleged resident to resident abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a long-term care home and to obtain an independent opinion with regard to any of those matters, and

The licensee failed to respect a resident's right to fully participate in decision process.

Rationale and Summary
Progress notes indicated that a resident expressed disagreement and dissatisfaction

about a decision made by the home that had direct impact on the resident.

The home actioned their decision without regard for the resident's input. the result was an adverse effect to the resident.

Sources: Resident's electronic health records, including progress notes and assessments; the home's policy titled Commitment to Resident - Centered Care and Resident Rights (RC-02-01-04) dated January 2022; Interviews with Administrator, director of care (DOC), Assistance director of care (ADOC). [000741]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care set out clear direction to staff regarding their identified needs related to an activity of daily living (ADLs).

Rationale and Summary
The documentation indicated that the resident was to be assisted with an ADLs at specific times. Upon review of the care plan, there were other interventions with different information related to timing of this activity. Interviews with an ADOC also confirmed that the outdated information should have been removed.

Although resident's care plan did not provide clear direction to staff, there was low

risk to the resident.

Sources: Resident's electronic health records, including their progress notes and care plan; the home's policy titled Plan of Care, (RC-05-01-01) last reviewed January 2022; Interviews with the DOC, ADOC, and other staff.[000741]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that an intervention was documented in full for a resident.

Rationale and Summary
A review of the intervention for a resident revealed missing documentation on several dates.

Interview with the DOC confirmed that the resident required this intervention, and the intervention should have been documented in full.

Incomplete documentation for a required intervention had little to no impact on the resident.

Sources: Resident's progress notes, assessments, and documentation of an

intervention; Interview with the DOC and other staff. [000741]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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,

1. The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments, when they exhibited a new area of altered skin integrity.

Rationale and Summary
A resident sustained an area of altered skin integrity during an incident. Upon review of the documentation there was no skin assessment completed for the resident.

Interview with an ADOC, indicated that skin and wound assessment should have been completed after the altered skin integrity was identified and every week after until it was healed.

The home failed to ensure that the skin and wound assessment was completed after the resident sustained an area of altered skin integrity, however the risk to the

resident was low.

Sources: Resident's health care records, including progress notes and assessments; the home's policy titled: RC-23-01-02: skin and wound program: Wound care management (last revised March 2023); Interviews with ADOC and other staff. [000741]

2. The licensee has failed to ensure that resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they exhibited a new area of altered skin integrity.

Rationale and Summary
A resident sustained a fall which resulted in an area of altered skin integrity. Within the resident's documentation there was no assessment of the area completed.

Interviews with an ADOC indicated that there was supposed to be an assessment completed every time a new wound or altered skin occurs, and re-assessment every week until healed.

There was low impact at the time of the incident to resident, after the home failed to ensure a skin assessment was completed.

Sources: Resident health records; progress notes; assessments; the home's policy titled: skin and wound program: wound care management, last reviewed March 2023,RC-23-01-02; Interviews with ADOC and other staff. [000702]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that a resident's behavioural trigger was identified, where possible.

Rationale and Summary
A resident demonstrated responsive behaviors towards another resident which resulted in injury. A resident with known responsive behaviors towards the other resident did not have documentation that identified them as a trigger for their responsive behaviour.

Interviews with staff indicated that the resident was a trigger for the other resident but was never identified or documented.

The home failed to identify a resident's potential triggers which posed a moderate risk to another resident at the time of the incident as staff may not have been aware of the resident's triggers resulting in the displayed responsive behaviours.

Sources: Resident's health care records; the home's policy titled Responsive Behaviors, (RC-17-01-04), last reviewed March 2023; Interviews with ADOC and BSO staff and other staff. [000702]