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
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Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: December 28, 2023

Inspection Number: 2023-1104-0008

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Falconbridge, Sudbury

Lead Inspector	**Inspector Digital Signature**
Shelley Murphy (684)	Shelley Murphy Digitally signed by Shelley Murphy Date: 2023.12.28 07:44:13 05'00'

Additional Inspector(s)
Loviriza Caluza (687)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4,-7, 2023

The following intake(s) were inspected:
One intake related to Improper/incompetent care of a resident;
One complainant related to resident neglect and staffing.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - No clear directions.

NC #001 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.

The licensee has failed to ensure that residents bath list in one home area, set out clear directions to staff and others who provided direct care to the residents.

Rationale and Summary
A complaint was submitted to the Director, which identified that residents personal care needs were being missed.

The home area bath list was reviewed, and was identified with multiple corrections, erasures, and conflicting information.

Assistant Director of Care (ADOC), acknowledged that the bath list did not provide clear directions to direct care staff due to the corrections and errors.

Failure to correct the residents bath list created confusion to staff members.

However, it presented low risk and low impact to the residents.

Sources: Complaint report; review of the home area bath list, residents' health care records, interviews with residents, direct care staff, and the ADOC.
[687]

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that all residents received their bath or shower as indicated in their care plan.

Rationale and Summary
Several residents were scheduled for a bath on several different days. The documentation report was not signed, and there were no progress notes to indicate that the baths had occurred.

In an interview with a resident, they indicated that had missed their baths as per the schedule, and two other residents also missed their baths.

ADOC was interviewed and indicated that the baths were missed and there was no documentation to support that the baths had occurred.

The home's failure to provide residents with their scheduled bath or shower as indicated in their care plan posed a minimal risk to the residents and the impact was low.

Sources: A complaint report; review of residents' care plan records, documentation reports, and bath lists; review of the licensee's policy titled "Daily Personal Care and Grooming" last reviewed January 2022; interview with residents, direct staff members, and ADOC.
[687]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The licensee has failed to ensure that a resident's altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Rationale and Summary
A CI report for Improper/incompetent care of a resident was submitted to the

Director related to wound care.

The resident's care plan indicated the following "[Wound Care Protocol] WCP to be performed as noted in Electronic Treatment Administration Record.

Upon review of the resident chart the following were noted:

There were several areas of skin impairment that required daily treatments, and the documentation did not support that the treatments were completed as prescribed.

The Inspector reviewed the documentation with staff and they confirmed that there was no documentation to show that the treatments were completed as prescribed.

The risk to the resident is moderate, as their wounds could have worsened due to wound care not being provided as prescribed.

Sources: CI Report, Resident's care plan, progress notes, skin and wound assessments, eTARs, home's policy Skin and Wound Program: Wound Care Management, RC-23-01-02, last reviewed October 2023, staff and ADOC interviews. [684]

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) (iv)
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,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that, when a resident had exhibited altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds they were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
The Inspector reviewed the resident's records and noted several weekly wound assessments were not completed.

During interviews with staff they confirmed that the wound assessments were not completed.

Sources: CI report, home's policy Skin and Wound Program: Wound Care Management, RC-23-01-02, last reviewed October 2023, a resident's eTARs, progress notes and wound assessments, and interviews with staff and the ADOC. [684]