

**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
Sep 10, 2021	2021_828744_0018	009436-21, 009460- 21, 010257-21	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 Timmins
62 St-Jean Avenue Timmins ON P4R 0A6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

STEVEN NACCARATO (744), SYLVIE BYRNES (627)

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): August 9-13, 2021.

The following intakes were inspected on during this inspection:

- One intake was related to the home's air temperature;**
- Two intakes were related to a fall that resulted in an injury.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Support Services Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, Maintenance staff, screener and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, infection prevention and control (IPAC) practices and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Infection Prevention and Control
Safe and Secure Home**

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

**3 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified in their plan.

An order was initiated for a resident to have a fall intervention. Staff were to ensure that the intervention was applied and functioning daily. On two separate days, a resident sustained a fall. In both incidences, the intervention had not been applied.

There was minimal risk of harm identified for the resident not having the intervention in place.

Sources: A resident's care plan; Digital prescriber's orders; The home's internal investigation notes; Interviews with the DOC and other staff. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff complied with the home's infection prevention and control program regarding hand hygiene for residents.

The home's policy indicated that staff were to assist residents to wash or sanitize their hands before and after meals. The Inspector did not observe the residents being assisted with hand hygiene prior to their meal being served. The Inspector was told that residents' hands were washed after the meal service, not prior to eating. The DOC stated that staff should be assisting residents with hand hygiene before and after meals.

Sources: Home's policy titled "Hand Hygiene", #IC-02-01-08, last reviewed June 2021"; Inspector observations; Interviews with the DOC and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

- i. a breakdown or failure of the security system,**
- ii. a breakdown of major equipment or a system in the home,**
- iii. a loss of essential services, or**
- iv. flooding.**

O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of a breakdown of major equipment or system in the home, that affected the safety, security or well being of one or more residents for a period greater than six hours.

In June 2021, a part of the air conditioning unit failed and was repaired the next day. The air conditioning breakdown lasted for 22 to 24 hours. The Inspector could not find a Critical Incident System report (CIS) on the online CIS reporting site. The Administrator confirmed that a CIS report had not been sent when the part of the air conditioning in the home had failed.

Sources: Intake #010257-21; Interviews with complainant, Support Service Manager, a maintenance worker, Administrator and other staff members; Temperature log for June 2021; and review of the CIS portal. [s. 107. (3) 2.]

Issued on this 21st day of September, 2021

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

Original report signed by the inspector.