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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date June 3, 2022
Inspection Number 2022_1115_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare Canada

Long-Term Care Home and City
Extendicare York, Sudbury.

Lead Inspector
Sylvie Byrnes #627

Additional Inspector(s)
Loviriza Caluza #687

Inspector Digital Signature
Sylvie Byrnes
2022.06.16 14:31:44 -04'00'

The inspection occurred on the following date(s): May 2-6, 9-11, 2022. Off site activities occurred on May 12-13, 2022.

The following intake(s) were inspected:

- One complaint related to shower rooms;
- One complaint related to continence care, meal services and complaint response; and,
- Five Critical Incident System (CIS) reports related to falls.

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Reporting and Complaints
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care for a resident were documented.

Rationale and Summary

A resident's care plan identified the resident's preferred method of bathing; however, they were frequently bathed by a different method due to responsive behaviors. There was no documentation in the resident's progress notes identifying what responsive behaviour the resident had exhibited, the alternative care provided and the outcomes of the care set out in the resident's plan of care. An RN acknowledged that the resident's responsive behaviour should have been documented along with the actions taken to address the responsive behaviour and what alternative care had been provided.

The lack of documentation of the resident's refusal of care and the outcomes of the care set out in the plan of care caused no risk to the resident as the home identified and implemented new interventions.

Sources: Interviews with complainant and staff members; record review, progress notes, the resident's care plan and task list, home's policy titled, "Bathing, Showering and Water Temperature Monitoring".

[#627]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, section 96 (1) (a).

The licensee has failed to ensure that maintenance services in the home were available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems were maintained in good repair.

Rationale and Summary

The home removed a shelter in the residents' smoking area; however, two posts, measuring 28.5 centimeters (cm) in circumference, and 3.8 cm in height above the ground remained. Both posts had ruts surrounding them. Multiple residents stated they had tripped or had been aware of others tripping by catching the wheels of their walkers or wheelchairs in the ruts surrounding the posts.

The remaining posts and the ruts beside the posts caused a moderate risk of fall to the residents.

Sources: Observations in residents' smoking area; interviews with residents, a substitute decision maker (SDM), and the Service Manager.

[#627]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s 6 (10) b.

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary

A resident was observed on two occasions eating independently in the dining room, during meal services. The resident's care plan identified that they required assistance from staff for eating. Two staff members identified that the resident ate independently and that the care plan would be updated to reflect the current needs of the resident.

The resident's care plan indicating they needed assistance to eat, when they ate independently caused no risk to the resident.

Sources: staff and resident observations; review of a resident's health care records; the home's policy titled "Plan of Care"; interview with staff members.

[#687]

WRITTEN NOTIFICATION: FALL PREVENTION AND MANAGEMENT

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 49 (2).

The licensee has failed to ensure that when a resident had a fall incident, the resident was assessed, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident fell while on a leave of absence (LOA). The ADOC/Falls Prevention Lead stated that when the resident had returned to the home, they were notified of the resident's fall but a post fall assessment was not completed.

The lack of a post fall assessment being completed when the resident fell while out on an LOA caused a moderate risk of further falls as the resident had complained intermittently of pain.

Sources: CIS report; resident and staff observations; review of a resident's health care records; the home's policy titled "Falls Prevention and Management Program and interview with the Falls Lead.

[#687]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee has failed to ensure that a resident was provided with eating aids and assistive devices required to safely eat and drink comfortably and independently as possible.

Rationale and Summary

A resident was observed at the lunch meal service with two beverages: one in a clear glass and one regular blue cup with a white straw. The resident's care plan and the Food and Fluids sheet both identified that they required a specific adaptive eating aid which had not been provided to the resident. The Food Service Supervisor (FSS) and the Food Service Manager (FSM) both verified that the resident required an adaptive eating aid and staff members were supposed to refer to the resident's Food and Fluid Sheets and follow it.

The resident not being provided with the required adaptive eating aid caused a moderate risk of the resident.

Sources: resident and staff observations; review of a resident's health care records; the home's policy titled "Meal Service"; interviews with staff members.

[#687]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10: s. 101 (1) 1.

The licensee has failed to ensure that a written complaint concerning a resident's care needs was investigated and resolved, and a response provided to the complainant within 10 business days of the receipt of the complaint.

Rationale and Summary

A complaint was sent to the home via email to the previous Director of Care (DOC) regarding a resident's care needs. The Administrator verified that there was a complaint that was brought forward regarding the resident's care needs via email to the previous DOC, but it was not addressed as it was missed.

The complainant not being provided with a response within 10 days of submitting the complaint, caused moderate harm to the resident as no actions were taken when the complaint was missed and the resident's specific care needs, identified in the complaint, were not addressed

Sources: Complaint log; review of a resident's health care records; the home's policy titled "Complaints and Customer Service", the complaint email from the complainant; interview with the complainant and the Administrator.

[#687]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s 6 (5).

The licensee has failed to ensure that the resident and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident's Physician prescribed a medication for them; however, the resident was only made aware of the new medication 75 days after receiving the new medication. The resident's designated person had not been notified. The DOC stated that the resident and their designated person should have been notified prior to the resident receiving the medication.

The resident being administered a medication without their, or their designated person's consent and knowledge, caused the resident to fear being administered medications without their knowledge.

Sources: Interviews with a resident and their designated person, Director of Care (DOC), an Acting Assistant Director of Care (ADOC); record review, Physician's order, progress notes, Home's policy titled, "Patient Counseling".

[#627]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s 138 (1) (a) ii.

The licensee has failed to ensure that drugs were stored in an area that was secured and locked.

Rationale and Summary

A medication room's door was left unlocked and open with no registered staff members in the area. Government stock medications and a non-stationary Emergency Supply Box (ESB) were visible to residents walking by the open medication room. An RN and the DOC both stated that the medication room and the ESB were supposed to be locked at all times as medications were stored in that room.

The medication room left open caused a moderate risk to residents as they were able to enter and access medication since no staff members were present at the nursing station at that time. Inappropriate ingestion of some of the stock medication could have caused a negative outcome to residents.

Sources: observations on a specific date; review of the home's policy titled ""The Medication Storage"; interview with an RN and the DOC.

[#687]

WRITTEN NOTIFICATION: INFECTION PREVENTON AND CONTROL

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2022, s. 102 (2) (b).

The licensee has failed to ensure that hand hygiene was provided to the residents prior to their meal being provided.

Rationale and Summary

The Inspectors observed two lunch meal services where residents were not offered or assisted with hand hygiene. The IPAC lead for the home stated that encouraging and assisting residents with hand hygiene was a passive process with signage posted at the doors, with hand sanitizer at the door and in the dining room for the residents to use independently.

The lack of assistance for hand hygiene prior to meals caused a moderate risk to the resident.

Sources: Inspector #627 and #687's observations for two meal services; record review, Infection Prevention and Control (IPAC) Standard, for Long-Term Care Homes, licensee's hand hygiene policy; interviews with the IPAC lead and other relevant staff.

[#627]

COMPLIANCE ORDER [CO#001]: PLAN OF CARE

NC#010 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 6 (7)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act. 2021

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

Specifically, the licensee shall prepare, submit and implement a plan to ensure the falls prevention interventions identified in two residents' plan of care are implemented.

The plan must include but is not limited to:

-The person(s) responsible for monitoring that the two residents' fall prevention interventions are implemented, and the frequency of monitoring and how it will be documented;

-The person(s) responsible for implementing an action plan if monitoring demonstrates the residents fall interventions are not being implemented; and

-Actions to address sustainability once the home has been successful in ensuring compliance with implementing the fall prevention interventions in two resident's plan of care.

Please submit the written plan for achieving compliance for inspection #2022_1115_0001, to Sylvie Byrnes, LTC Homes Inspector, MLTC, by email to SudburySAO.moh@ontario.ca by June 10, 2022

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

Non-compliance with: FLTCA, 2021, s 6 (7).

The licensee has failed to ensure that the care set out in two resident's plan of care, for the focus of falls, was provided to two resident as specified in the plan.

Rationale and Summary

a) A resident's care plan, for the focus of falls, identified two specific interventions to reduce their risk of falls. On two separate occasions, the resident was observed without one of the interventions in place. A PSW acknowledged that the resident should have had the two specific interventions in place to reduce their risk of falls.

The resident not being provided with the two specific interventions related to falls caused a moderate risk of fall to the resident.

Sources: Observations of a resident; interviews a PSW and other relevant staff members, Acting Assistant Director of Care (ADOC); record review, resident's care plan, home's policy titled, "Plan of Care". [#627]

b) A resident sustained a fall which caused an injury. The resident's care plan identified a specific intervention that had not been implemented when the resident fell. An RPN and the Fall Prevention Lead verified that the specific intervention was not implemented when the resident fell.

As the resident was identified as high risk for falls, not having the specific intervention in place during a specific activities of daily living placed the resident at high risk for falls.

Sources: CIS report; review of resident's health care records; the home's policy titled "Plan of Care"; interview with the resident, an RPN and the Falls Prevention Lead. [#687]

c) On two separate occasions, a resident was observed with a fall intervention identified in the care plan not in place, during a specific activity of daily living. Two PSWs and the RN stated that the specific intervention was to be in place during a specific activity of daily living as a falls prevention intervention.

As the resident was identified as high risk for falls, not having the specific intervention in place during a specific activities of daily living placed the resident at high risk for falls.

Sources: CIS report; observations of the resident and their environment and the staff members; review of the resident's health care records; the home's policy titled "Plan of Care"; interview with the resident and staff members. [#687]

This order must be complied with by July 15, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care

438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.