Ontario

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

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

North District

159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: January 5, 2023	
Inspection Number: 2022-1115-0003	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare York, Sudbury	
Lead Inspector Lisa Moore (613)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 12-14, 2022.

The following intake(s) were inspected:

- Intake related to allegations of abuse
- Intake related to neglect
- Intake related to improper medication management
- Intake related to medication error resulting in transfer to hospital.

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

Prevention of Abuse and Neglect
Resident Care and Support Services
Medication Management

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected and not neglected by a PSW.

Rationale and Summary: A RPN became aware that a resident had not received any care by a PSW during a shift.

The home's investigation determined that the neglect was founded and there was no documentation to demonstrate that care had been provided to the resident by the PSW.

Assistant Director of Care (ADOC) verified that a resident had not received required care by the PSW on a specific shift and that the RPN should have realized sooner that a resident had not received any care, during the shift, as they were the Supervisor on the unit.

The failure of a PSW not providing the required care to a resident resulted in moderate impact and risk, as they did not receive their required care.

Sources: CI report; internal investigation file; resident's care plan and

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progress notes; LTC home's abuse policies; and interview with ADOC. [613]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

The licensee has failed to ensure that a RPN immediately reported the neglect of a resident to the Director.

Rationale and Summary: A RPN discovered that a resident had not received any care by a PSW during a shift. The RPN did not immediately notify the Manger on-call or the Director of the Ministry of Long-Term Care. The ADOC did not become aware of the incident until two days after the incident occurred.

ADOC stated that the RPN should have reported the neglect of the resident immediately.

The impact and risk to the resident was low when the RPN did not notify the Director or their Supervisor immediately of the neglect.

Sources: CI report; internal investigation file; resident's progress notes; LTC home's abuse policies; and interview with ADOC. [613]

WRITTEN NOTIFICATION: Administration of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for as specified by the prescriber.

Rationale and Summary: A resident received orders for a specific medication to remain on hold, from a previous order, and to resume the medication on a specific date. A RN failed to process the new order completely onto the electronic medication administration record (eMAR) when it was received, resulting in a RPN administering the medication on a specific date and time.

The DOC stated that the RN did not process the new order completely onto the eMAR, resulting with a RPN administering the medication to the resident.

The failure of registered staff not ensuring that drugs were administered to the resident in accordance with the directions for as specified by the prescriber resulted in moderate impact and risk to the resident.

Sources: CI Report; resident's MAR, progress notes; internal investigation file; Medication Management Policy; and interview with DOC. [613]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was

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provided to a resident as specified in their plan.

Rational and Summary: A PSW attempted to provide continence care to a resident without the assistance of another staff member.

The resident's care plan, at the time of the incident, indicated that the resident required two staff members to provide care.

An ADOC verified that the PSW did not follow the resident's plan of care and should not started their care alone without another staff member assisting.

The impact and risk to the residents was low when the PSW did not follow the resident's care plan.

Sources: CI report; internal investigation file; resident's care plan and progress notes; and interview with ADOC. [613]