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: August 1, 2023

Inspection Number: 2023-1115-0005

Inspection Type:
Follow up
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare York, Sudbury

Lead Inspector	**Inspector Digital Signature**
Amy Geauvreau (642)	Amy Geauvreau Digitally signed by Amy Geauvreau Date: 2023.08.04 14:45:04 -04'00'

Additional Inspector(s)
Chad Camps (609)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-14, 2023.

The following intake(s) were inspected:

- Intake: related to medication administration.
- Intake: related to alleged improper/incompetent care.
- Intake: related to alleged abuse.
- Intake: - Follow-up #1- High Priority CO #001 / 2023_1115_0004, FLTCA s. 5, safe and secure home.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1115-0004 related to FLTCA, 2021, s. 5 inspected by (642).

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

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

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

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the care set out in the plan had not been effective.

Rationale and Summary

As a result of a resident's behaviour towards another resident, staff were to provide a focused intervention when this resident was in a specific area.

On different days, the resident was observed in this specific area, and the staff were not providing the required focused intervention.

Personal support staff as well as registered staff described how they were unable to provide the required focused intervention for this resident, while they were in this specific area.

The Assistant Director of Care (ADOC) acknowledged that to effectively provide the focused intervention for this resident while in this specific area, would require changes to the resident's plan of care.

Sources: Critical Incident (CI) report; Resident plan of care; The home's policy titled "Plan of Care" RC-05-01-01 last reviewed January 2022; Observations of the resident; Interviews with Personal Support Worker (PSW); Registered Practical Nurse (RPN); and the ADOC. [609]

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that actions taken to respond to a resident's demonstrated responsive behaviours, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary

a) An RPN conducted an assessment after a Recreational Aide (RA) reported to them that an incident had occurred between two residents.

However, after review of the two residents' health care records there was no mention of the actions, assessment, or any subsequent interventions of the incident conducted by the RPN.

Within a few days of the reported incident, the home became aware that the same residents had been involved in another incident.

Registered staff verified that they were expected to document any assessment of a resident's behaviours.

The Director of Care (DOC) verified that the RPN should have documented their assessment of the incident and the two resident's behaviours that first day when it was reported.

b) A Registered Nurse (RN) removed a resident's plan of care intervention.

A review of the resident's health care records found no mention of the RN's actions, assessment, or reassessment when they removed the resident's intervention.

The ADOC verified that the RN should have documented their assessment when they revised this resident's behavioural plan of care.

The home's failure to ensure that the RPN and RN actions, assessments, and/or reassessments of the resident's behaviours were documented presented moderate risk of harm to other residents.

Sources: CI report; Residents plan of care and health care records; Interviews with RPN; ADOC; and DOC. [609]

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