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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Original Public Report

Report Issue Date: November 1, 2024
Inspection Number: 2024-1115-0004
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare York, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31 and November 1, 2024.

The following intake(s) were inspected:

- Intake, Critical Incident (CI) submitted for improper / incompetent care of a resident resulting in injury;
- Intake, for a complaint submitted to the Director for concerns regarding improper care and a fall of a resident; and,
- Intake, submitted for an allegation of neglect of a resident by staff.

The following Inspection Protocols were used during this inspection:

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in the different aspects of a resident's care, collaborated with each other in that registered staff did not clarify a Physician's order related to their care.

Sources: A resident's Physician Orders; the home's investigation notes; and interview with the Associate Director of Care (ADOC).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that direct care staff used safe positioning measures when they assisted a resident with care, which resulted in the resident sustaining an injury.

Sources: CI report; a resident's health care records; the Long-Term Care Homes (LTCHs) internal investigation notes; staffs personnel file; and interviews with the resident, and ADOC.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's individualized plan of care for the management of their continence was implemented.

Sources: A resident's health care records; the home's investigation notes; and interview with the ADOC.