Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2015	2015_380593_0010	S-000785-15	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 30 - 31, April 1, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Activity Staff, Personal Support Workers (PSW), residents and family members.

The Inspector observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed resident's environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when making a report to the Director under

subsection 23 (2) of the Act, the final report is provided to the Director within a period of time specified by the Director.

A Critical Incident (CI) was submitted to the Director, in relation to a reported staff to resident verbal abuse occurring in March, 2015. The licensee was first made aware of the allegation when resident #001 first reported this to a registered staff member on an afternoon in March, 2015. The CI was submitted to the Director shortly after.

A review of the CI by Inspector #593, found that the CI was amended to include the analysis and follow-up as the investigation had been completed. The CI was amended on a day in March, 2015 at 13:24. The accused employee resigned thirteen days earlier and the home met with the resident's Power of Attorney (POA) the day after the employee resigned to provide the results of the investigation. The CI was not completed with these results until 12 days later after the investigation was completed.

During an interview with Inspector #593 April 1, 2015, the home's DOC #s-108 advised that they had completed the CI with results of the investigation only recently and that there was no reason as to why this was completed nearly two weeks after the investigation was completed.

A memorandum was sent to all Ontario Licensees and Administrators February 12, 2015 in regards to clarification of Mandatory and Critical Incident reporting requirements. Regulation, section 104- Licensees who report investigations under subsection 23 (2) of the Act:

"The licensee must report to the Director the results of the investigation and the action(s) taken. This report to the Director must be in writing and section 104 of the Regulation sets out what information must be included in the report. Licensees must submit this report to the Director within 10 days of the licensee becoming aware of the incident or at an earlier date if required by the Director. If the licensee cannot provide all of the material mandated by subsection 104(1) then the licensee must submit a preliminary report to the Director within 10 days of the licensee becoming aware of the incident and must provide a final report within a period of time specified by the Director. In a separate memo dated March 28, 2012 the Director identified that the final report must be submitted in 21 days unless otherwise specified by the Director."

The licensee was first made aware of the incident on a date in March, 2015, however the final report was not submitted until 26 days after first becoming aware of the incident. [s.

104. (3)]

Issued on this 30th day of April, 2015

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

Original report signed by the inspector.