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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 5, 2016	2016_282543_0022	000101-16, 016918-16, 018355-16, 018640-16	Complaint

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

TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 22-24, June 27-30 and July 4, 2016.

This Complaint inspection is related to four complaints; 000101-16 related to care of a resident, 016918-16 related to insufficient staffing, 018355-16 related to alleged resident to resident abuse and 018640-16 related to responsive behaviours.

A Critical Incident Inspection #2016_282543_0021 was conducted concurrently with this inspection.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and staff personnel files.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director(s) of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Registered Dietician (RD), Dietary Manager, Restorative Care Manager/Kinesiologist, residents and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #543 reviewed a complaint related to insufficient staffing in the home. According to the complaint, in May 2016, the home was short staffed and residents were still in their night briefs on day shift, and that the clean briefs were left at the end of the bed as if the night shift had planned to use but had not had the time. The complainant stated they were concerned about the short staffing issues at the home and felt like if it continued there was going to be an accident.

The Inspector reviewed the home's staffing plan, with a review date of October 2015, which identified the following staffing mix for the home:

Personal Support Workers (PSWs): total of 28 for a day shift (unit two-9, unit three-10 and unit four-9), 28 for an evening shift (unit two- 6 at 5.5hrs and 3 at 7.5 hrs; unit three-7 at 5.5 hrs and 3 at 7.5 hrs; unit four-6 at 5.5hrs and 3 at 7.5 hrs) and six for a night shift (two on each unit).

Registered Practical Nurses (RPNs): six on day shift (2 per unit), six on evening shift (2 per unit) and three on night shift (1 per unit).

Registered Nurses (RNs): three for a day shift, two for an evening shift and one for a night shift.

The Inspector reviewed the home's Communication Sheet for Staffing for June 19, 2016. This sheet was utilized in the home to indicate which shifts needed to be replaced and if the shift was replaced and by whom. The Inspector identified that on the above mentioned date that the home was unable to replace 16 shifts for that day.

On June 19, 2016-units two, three and four worked in Plan C (short 2 staff members) on evening shift. The Inspector reviewed some residents who were scheduled for a bath or shower on that shift. Eight residents from unit two were scheduled for a bath or shower, the inspector identified that one resident had not received their bath or shower. Ten residents from unit three were scheduled for a bath or shower, the inspector identified that three residents had not received their bath or shower. Eight residents from unit four were scheduled for a bath or shower, the inspector identified that four residents had not

received their bath or shower. Of the 26 residents reviewed on that date where units two, three and four worked short staffed, 31% of the residents had not received their scheduled bath or shower.

The Inspector spoke with resident #009 who verified that the home was frequently short of staff. They stated that there were times when they have waited long periods of time to be toileted, and had been told to use their brief to go to the bathroom if they could not wait. This resident indicated that they have witnessed staff running around, with little time to get their tasks done. This resident's family member was present during the conversation and indicated there have been times when the resident had phoned them crying because they waited too long to be brought to the bathroom.

The Inspector spoke with RPN #123 and #124 who stated that it happened often enough that they worked short staffed. They verified that medication passes take much longer to complete, that daily vitals and blood sugar monitoring were not getting done in a timely manner. They also explained that breaks have been affected, PSWs often gave up their breaks to shower and or bathe residents. They indicated that residents had to wait long periods of time for assistance with ADLs and toileting.

The Inspector spoke with PSW #126 and #127 who verified that it occurred often enough that they worked short staffed, and that it has impacted resident care. They indicated that frequently residents will not get their bath or shower when the staff have worked short.

The Inspector spoke with PSW #128 who stated the home was short staffed all the time and shifts were not always replaced. They indicated that working short staff has impacted resident care, resulting in residents having to wait long periods of time to get assistance. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm had occurred or may immediately reported the suspicion and the information upon which it is based to the Director.

Inspector #543 reviewed a complaint, related to alleged abuse of resident #005 by another resident. According to the complaint, resident #005 was struck by another resident twice in May 2016. The complainant reported that resident #005 sustained a injury from one of the incidents in May 2016.

The Inspector reviewed resident #005's progress notes, which indicated that this resident was grabbing out at resident #008, who then struck resident #005. Documentation indicated that resident #008 was near resident #005, and was attempting to grab out at resident #008. Resident #008 then struck resident #005.

On June 22, 2016, the Inspector spoke with the complainant who verified that resident #005 was struck on two separate occasions in May 2016. They stated that the resident sustained an injury on one of the occasions. The complainant indicated they spoke with the DOC about the incidents and was informed that the home would be dealing with the incidents internally.

On June 24, 2016, Inspector #543 spoke with ADOC #107, who stated they were aware of one incident that occurred with resident #005, where they were struck in the face. ADOC #107 verified they had not submitted the incident to the Ministry, and was unaware if someone else from management had reported it.

On June 24, 2016, the Inspector spoke with the Administrator and ADOC #106 who verified there were two incidents in May where resident #005 was struck by another resident. They indicated that they did not report these incidents to the Director.

On June 30, 2016, the Inspector spoke with the DOC who verified that resident #005 was struck in the face on two separate occasions. The DOC indicated that they had not reported these incidents to the Director, as there were no immediate injuries noted to the resident on both occasions. They stated that the home handled both incidents internally. [s. 24. (1)]

Issued on this 6th day of October, 2016

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

Original report signed by the inspector.