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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 25, 2018	2018_744693_0003	024673-17, 025972-17, 001814-18, 005708-18	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

MELISSA HAMILTON (693), MICHELLE BERARDI (679), SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 17-20, 2018.

During this Critical Incident System (CIS) inspection: one intake related to an unexpected death, two intakes related to resident falls, and one intake related to the infection prevention and control program were inspected.

A Complaint inspection #2018_746692_0001 and a Follow Up inspection #2018_745690_0002 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Restorative Care Aides, family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in residents were recorded.

A Critical Incident System (CIS) report was submitted to the Director for an unexpected death. The CIS report identified that resident #007 was diagnosed with an illness and was being treated with an intervention when they died unexpectedly.

Inspector #690 noted that it was documented in the progress notes for resident #007 that they were receiving a specific intervention for an illness starting on a specified date. The progress notes did not identify the discontinuation of the intervention.

During a review of the electronic progress notes for resident #007, Inspector #690 identified that on a number of shifts staff did not document resident #007's symptoms of infection.

A review of policy titled "Isolation: IC-03-01-12" last updated September 2017, was conducted. The policy indicted that progress notes were used to indicate the assessment process as well as the action taken to determine that isolation was required.

In an interview with Inspector #690, RN #129 identified that symptoms were tracked on every shift in the past, however they believed the tracking of symptoms had changed to daily. Inspector #690 and RN #129 reviewed the electronic progress notes; RN #129 identified that resident #007's symptoms of infection should have been documented in the electronic progress notes.

In an interview with Inspector #690, ADOC #115 identified staff were to document on resident #007 daily, but that the note did not always include symptoms. Inspector #690 and ADOC #115 reviewed the electronic progress notes and ADOC #115 confirmed that on several shifts there was no documentation related to resident #007's symptoms of infection.

In an interview with Inspector #690, the DOC identified that there should have been documentation at least once a shift on resident #007's symptoms of infection especially because they were being treated with a specific intervention. [s. 229. (5) (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 ensuring that on every shift, symptoms indicating the presence of infection in residents are recorded and immediate action is taken as required, to be implemented voluntarily.

Issued on this 25th day of April, 2018

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

Original report signed by the inspector.