Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2020	2020_828759_0002	024049-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

KEARA CRONIN (759), RYAN GOODMURPHY (638)

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): January 14-17 and 20, 2020

The following intake was completed in this Critical Incident inspection:
- One intake relating to a missing resident.

A complaint inspection #2020_828759_0003 was completed concurrently with this inspection.

The Inspector conducted daily observations of the provision of care that was provided to residents, reviewed relevant health care records, policies and procedures, and internal investigation notes.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care(s), Registered Nurses, Registered Practical Nurses, Personal Support Workers, the front desk receptionist, residents and families.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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	Légende 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, resident #001 who demonstrated responsive behaviours, had strategies developed and implemented to respond to those behaviours.

A Critical Incident (CI) report was submitted to the Director on a specified date, related to an incident that occurred the day prior. The CI report indicated that resident #001 was missing and was found away from the home.

Inspector #759 reviewed resident #001's electronic health care records on Point Click Care (PCC) and identified a progress note written by Registered Nurse (RN) #105. The progress note indicated that RN #105 was notified by office staff that a call was received from an unknown citizen and the caller stated there was a pedestrian observed that they suspected was a resident of the home. The progress note went on to describe that resident #001 was identified as missing at a later time and the note identified the time that resident had last been seen by a Registered Practical Nurse (RPN) in their home area.

Inspector #759 further reviewed the home's internal investigation notes that related to the incident and progress notes on PCC. The Inspector identified that resident #001 demonstrated a specific number of episodes of a responsive behaviour.

Inspector #759 interviewed Personal Support Worker (PSW) #120, who indicated that resident #001 only displayed a specific responsive behaviour when they exhibited a specific indicator.

Inspector #759 interviewed the Behavioural Support Ontario (BSO) RPN #106, who identified that resident #001 had a responsive behaviour at specific times where they would exhibit further responsive behaviours.

Upon review of resident #001’s progress notes, Inspector #759 identified a progress note written on a specified date by BSO RPN #106 that was titled “BSO Team Data: BSO monthly review”. It indicated the resident's responsive behaviours had increased.

Inspector #759 identified an additional progress note on a specified date written by BSO RPN #106. They indicated that they reviewed the incident, with the Director of Care (DOC) and they introduced a new intervention for a responsive behaviour. The intervention indicated that it was the staffs responsibility to implement this intervention.

Inspector #759 reviewed resident #001's current care plan and identified the intervention relating to the responsive behaviour that outlined the intervention for all staff members to implement.

Inspector #759 interviewed various staff members regarding the specified intervention for resident #001:

Personal Support Worker (PSW) #121 indicated that they were told to implement the intervention for resident #001. They further indicated that it was up to the various disciplines of staff to implement the intervention.

Staff member #113 stated they were asked to implement the intervention. When Inspector #759 asked them if they implemented the intervention, they replied “not really”, although they did as much as they could.

BSO PSW #120 indicated that the intervention was implemented in a specific way.

BSO RPN #106 indicated that they verified the intervention for resident #001. They further stated that they implemented the intervention when the resident exhibited a specified indicator, although that was not stated in the care plan. The BSO RPN #106 also shared that resident #001 was too unpredictable to have a schedule for the intervention.

RN #117 stated that the intervention was not being done, especially when the home was short staffed, they stated it was not possible.

During an interview between Assistant Director of Care (ADOC) #102 and Inspector #759 , ADOC #102 stated that staff tried to implement the intervention for resident #001 and that in general it was unrealistic to implement the intervention at specific time intervals because if resident #001 became aware of the intervention, it would trigger another responsive behaviour.

Inspector #759 interviewed the Administrator, who indicated that staff implemented the intervention more frequently when the resident displayed specific indicators. The Administrator confirmed that it did not specifically identify this approach in the care plan, although there was a lot of staff involvement with resident #001.

The licensee failed to implement strategies that were developed for resident #001. Inspector #759 was unable to identify specifically how the staff members were implementing the intervention for resident #001. [s. 53. (4) (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 strategies are developed and implemented to respond to the responsive behaviours of resident #001, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident where resident #001 was missing for less than three hours and then returned to the home with no injury or adverse change in condition within one business day.

A CI was submitted to the Director regarding a resident elopement (please see WN #1 for more details).

Inspector #759 reviewed the home's internal investigation notes that was related to an incident in which resident #001 was missing on a specific date. The Inspector noted a document created on a specified date, which described another incident whereby resident #001 went missing.

The policy titled "Critical Incident Reporting RC-09-01-06" last updated June 2019, directed the DOC or designate to "inform the [Ministry of Long-Term Care] Director no later than one business day after the occurrence of the incident of: a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition".

During an interview with the DOC and Inspector #759, the DOC confirmed that this incident was not reported and they were not aware at the time of the incident and that it should have been reported. [s. 107. (3) 1.]

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.