Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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
Oct 14, 2020	2020_679687_0011	016985-20, 019225-20	Complaint

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

LOVIRIZA CALUZA (687), RYAN GOODMURPHY (638)

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): October 4-8, 2020.

The following intakes were inspected during this Complaint inspection:
- One intake regarding resident care concerns on weight loss and continence care, and
- One intake regarding a resident's family seeking information on health care records from the nursing home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Support Services Manager, Physician, Kinesiologist, Registered Dietician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Unit Clerks, the Hairdresser, residents and family members.

The Inspector also conducted a daily tour of resident home areas, observed the provision of care and services to the residents, reviewed relevant health records, as well as reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's written plan of care regarding their safety alarm set out clear directions to staff and others who provided direct care to the resident.

A resident had two separate fall incidents; it was identified that their safety alarm was not applied, and the alarm was turned off. A documentation record indicated that the resident's safety alarm was implemented due to the many unsafe self-transfer attempts by the resident, but the care plan record did not show that the resident required the use of a safety alarm at any time. During an interview with the ADOC, they indicated that registered staff were in charge of updating the plan of care and that the resident's care plan should have identified the need for the resident's safety alarm.

Sources: Resident's progress notes and care plan, interview with a PSW, an ADOC and other staff members. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a resident's substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care after a fall incident.

A resident had an injury which required a skin integrity intervention after a fall incident. It was identified that the substitute decision maker was to be notified by a registered staff. In an interview with the Registered Nurse (RN), they indicated they had failed to notify the family regarding the resident's fall incident.

Sources: Resident’s progress notes and care plan, 24-hour shift to shift report, the home’s policy on Falls Prevention and Management, interviews with an RN, an ADOC and other staff members. [s. 6. (5)]

3. The licensee has failed to ensure that the resident had their safety alarm applied as specified in the plan.

a) A resident was at high risk for falls and required a safety alarm for safety as the resident would attempt to self-transfer. The resident was observed in their mobility aid and their safety alarm was not applied. In an interview with the RN, they indicated that the resident’s safety alarm should have been applied to the resident.

Sources: Resident’s progress notes and care plan, observations, interview with an RN, an ADOC and other staff members.

b) A resident was identified in their care plan as at risk of harm and would require safety alarms. On two separate fall incidents, the resident did not have their safety alarm as it was missing, and the alarm did not sound at the time of the fall. During an interview with the ADOC, they acknowledged that the staff were supposed to ensure that the safety alarm was in place and functioning as per the resident’s plan of care.

Sources: Resident’s progress notes and care plan, interview with a PSW, an ADOC and other staff members.

c) A resident was identified in their care plan as at risk of harm to self and the staff were to monitor the placement and functioning of the resident’s safety alarms. A fall incident had occurred and it was identified that the resident’s safety alarm did not sound at that time as the staff were uncertain if it was attached or not. In an interview with the ADOC, they indicated that staff were supposed to ensure that the safety alarm was in place and functioning as per the resident’s plan of care.

Sources: Resident’s progress notes and care plan, interview with a PSW, an ADOC and other staff members. [s. 6. (7)]

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 the resident's written plan of care set out clear directions to staff and others who provide direct care to the resident; the resident's substitute decision-maker is given the opportunity to participate fully in the development and implementation of the resident's plan of care, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 15th day of October, 2020

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

Original report signed by the inspector.