

**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**Sudbury Service Area Office
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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
Sep 10, 2021	2021_908642_0003	005840-21, 010728-21	Critical Incident System

Licensee/Titulaire de permisExtendicare (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**

AMY GEAUVREAU (642)

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): August 19-20, 23-26, 2021.

The following intakes were inspected during this inspection:

One intake related to alleged concerns about a resident's actions towards another resident.

One intake related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), the Assistant Director of Care (ADOC) and Infection Prevention Program Lead, Registered Dietitian (RD), Housekeeping staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted a daily tour of the resident care areas, reviewed relevant resident records and policies, the Infection Prevention and Control (IPAC) practices were reviewed, investigations notes and interviews and observed resident rooms, resident common areas, dining areas, reviewed recorded temperatures, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

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

**WN #1: 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 when they were informed of an alleged abuse incident between two resident's on a specific day, the suspicion and the information was immediately reported to the Director.

The review of the Critical Incident (CI) report identified this incident was reported late to the Director.

A Registered Practical Nurse (RPN) found a resident in their bedroom and they were afraid and fearful of their roommate. The on call Manager had been notified at that time.

The Director of Care (DOC), stated the alleged incident of abuse between these two resident's, should have been reported immediately to the Director.

Sources: Critical Incident; Zero Tolerance of Resident Abuse and Neglect Program policy, revised June 2021; progress notes for the two resident's; Interviews with DOC, and other staff. [s. 24. (1)]

Issued on this 24th day of September, 2021

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

Original report signed by the inspector.