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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
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Original Public Report

Report Issue Date July 18, 2022
Inspection Number 2022-1104-0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc

Long-Term Care Home and City
Extendicare Falconbridge, Sudbury

Lead Inspector
Shelley Murphy #684

Inspector Digital Signature
Shelley Murphy
Digitally signed by Shelley Murphy
Date: 2022.07.20 11:55:41 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 20-24, 2022.

The following intake(s) were inspected:

- Two logs related to alleged staff to resident physical abuse;
- One log related to alleged staff to resident neglect; and
- One Log related to falls.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

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NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 184 (3)*

The licensee has failed to ensure that the home carried out every operational or policy directive issued by the Minister that applied to the long-term care home.

Rationale and Summary
The inspector reviewed the daily resident temperature logs. It was noted on one resident area that multiple residents had not had their temperature checked on a specified day.

Minister Directive: COVID-19 Response Measures for Long-Term Care Homes dated June 11, 2022, stated "Homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks".

During an interview with a staff member, they confirmed that resident temperatures were to be taken every day and had not been taken on the specified day, as they were extremely busy that day.

The IPAC lead said it was the expectation that resident temperatures were obtained daily as per the Minister's Directive. They reviewed the temperature log and confirmed that multiple residents had not had their temperature checked.

Sources: Resident temperature log, Minister's Directive dated June 11, 2022, Home's policy Coronavirus (COVID-19) IC-05-01-13, last reviewed April 2022, staff and IPAC lead interview.

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WRITTEN NOTIFICATION: POLICIES AND RECORDS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 20 (1)

The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Rationale and Summary
Critical Incident System (CIS) report was reviewed and indicated that a resident was assessed for injury and that no injury was identified.

During the review of the resident's progress notes and assessments the inspector was unable to locate documentation of the assessment that was completed, after an allegation of abuse.

The home's policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, stated; "Ensure the safety of and provide support to the abuse victim(s), through completion of full assessments, a determination of resident needs and a documented plan to meet those needs".

Assistant Director of Care (ADOC) reviewed the progress notes and assessment sections in Point Click Care (PCC) electronic documentation and was not able to locate documentation to support that the assessment had been completed.

Sources: CIS report, resident's progress notes and assessments, Home's policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02, last reviewed January 2022, and the ADOC interview.

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WRITTEN NOTIFICATION: DUTY TO PROTECT

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s. 19 (1)*

The licensee has failed to ensure that two residents were protected from abuse and neglect by a staff member.

Rationale and Summary

Two residents were treated inappropriately by a staff member on the same day.

ADOC confirmed that the residents were abused, and the staff member was terminated.

Sources: CIS report, staff file, home's policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-01, last reviewed January 2022, and ADOC interview

Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse by a staff member.

Rationale and Summary

During a review of a resident's progress notes, there was a note that indicated that a certain intervention was implemented for the resident, and this was not part of the resident's care plan. As per the CI report, ADOC interviewed and assessed the resident. The resident could not recall the incident and had no injuries or ill effects.

In a letter to the staff member indicated that they chose this action to help prevent a potential adverse effect and it was explained to them that this was not an appropriate intervention.

ADOC confirmed that the resident was abused by the staff member and therefore the staff member was terminated.

Sources: Resident progress notes, home's policy-Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01 last reviewed January 2022, Home's Investigation Closure notes, Employee file, and ADOC interviews.

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