Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: May 3, 2023

Inspection Number: 2023-1104-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Falconbridge, Sudbury

Lead Inspector	**Inspector Digital Signature**
Steven Naccarato (744)	Steven C Naccarato Digitally signed by Steven C Naccarato Date: 2023.05.05 15:25:22 -04'00'

Additional Inspector(s)
Sylvie Byrnes (627)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-31 and April 3-4, 2023.

The following intake(s) were inspected:

- One intake was related to an unsafe transfer of a resident.
- One intake was related to a fall of a resident resulting in an injury.
- One intake was related to resident to resident physical abuse.
- Two intakes were related to an unexpected death of a resident.
- One intake was related to a complaint concerning dining service and emergency plans.
- One intake was related to staff to resident sexual abuse.
- One intake was a complaint related to an unexpected death of a resident.
- One intake was related to staff to resident physical abuse.

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

Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

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 policy directive related to indoor staff mask use that applied to the home was carried out.

Rationale and Summary

Minister's Directive "COVID-19 response measures for long-term care homes", indicated that the licensee was required to follow the "COVID-19 guidance document for long-term care homes in Ontario", which required all staff to wear a medical mask for the entire duration of their indoor shift.

A critical incident submitted to the Director, indicated that a Personal Support Worker (PSW) had removed their mask multiple times in close proximity to a resident, while in indoor resident areas.

The IPAC lead verified that staff must always wear masks when in close proximity to residents.

The home's failure to ensure that all staff adhered to the Minister's Directive was a moderate risk to residents due to the possible transmission of various pathogens.

Sources: "Minister's Directive: COVID-19 response measures for long-term care homes" effective August 30, 2022; A Critical Incident; The home's internal investigation notes; The home's policy titled "Coronavirus (COVID-19)" last updated January 2023; Interviews with the IPAC lead and other staff. [744]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident was injured during a mechanical lift transfer completed solely by one staff member.

The Director of Care (DOC) indicated that two trained staff are required to operate a mechanical lift when transferring a resident. One person to operate the lift and another person to ensure the resident's safety.

The home's failure to ensure that staff used safe transferring techniques when assisting a resident, caused minimal harm.

Sources: A Critical Incident; The home's policy titled "Mechanical Lifts" last updated July 2022; Interviews with the DOC and other staff.

[744]