Ontario

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

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspection Branch

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

**Original Public Report**

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| **Report Issue Date:** April 5, 2023. | |
| **Inspection Number:** 2023-1125-0002 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Extendicare (Canada) Inc. | |
| **Long Term Care Home and City:** Extendicare Tri-Town, Haileybury | |
| **Lead Inspector**<br>Sylvie Byrnes (627) | **Inspector Digital Signature**<br>Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2023.04.13 10:35:47 -04'00' |

## INSPECTION SUMMARY

The Inspection occurred on the following dates(s): March 6-9, 2023.

Additional off-site activities were completed on March 16, 2023.

The following intake(s) were inspected:

- One intake related to an unexpected death; and,
- One complaint related to suspected abuse.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management

Infection Prevention and Control

Prevention of Abuse and Neglect

Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting and Complaints

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had grounds to suspect that improper treatment of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rational and Summary

A family member reported to a Registered Nurse (RN) that a resident had a new unexplained injury. The Administrator/Director of Care (Admin/DOC) stated they reported the incident to the Director the following day as they had not realized the severity of the incident when they had spoken to the RN.

Late reporting of a resident's unexplained injury caused no harm to the resident.

Sources: Interviews with a resident's family member, an RN and Admin/DOC; record review: resident's progress note and Home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", #RC-02-01-02.
[627]

### WRITTEN NOTIFICATION: Skin and wound care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2

The licensee has failed to comply with the skin and wound care program when a resident developed an unexplained injury.

In accordance with Ontario Regulations (O. Reg.) 246/22 section (s) 11 (1) (b), the licensee is required to have a skin and wound care program that must be complied with.

Specifically, an RN did not comply with the home's skin and wound care management policy.

Rational and Summary

A resident had an unexplained injury which required monitoring as indicated in the home's skin and wound care policy by a nurse using a clinically appropriate assessment instrument.

The lack of completing a skin and wound assessment for the resident caused no harm to the resident.

Sources: Interviews with a resident's SDM, an RN, Admin/DOC; Record review of a resident's progress note, home's policy titled, ""Skin and Wound Program: Wound Care Management", #RC-23-01-02.

[627]

**WRITTEN NOTIFICATION: Infection Prevention and Control**
**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure the infection prevention and control lead worked 17.5 hours per week in that position.

The infection prevention and control (IPAC) lead stated that they worked in the home in multiple roles including IPAC lead, and that they dedicated less than 17.5 hours per week to the role.

The IPAC lead not working 17.5 hours in the IPAC role caused low risk to the residents.

Sources: Interview with IPAC lead.
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