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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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 26, 2021	2021_901759_0009	009864-21, 011949-21, 012066-21, 014401-21	Critical Incident System

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 York
333 York Street Sudbury ON P3E 5J3

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

KEARA CRONIN (759), LOVIRIZA CALUZA (687)

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): October 4-8, and 12-15, 2021.

The following intakes were inspected upon during this Critical Incident System Inspection:

- Two intakes related to two falls resulting in an injury to two residents;
- One intake related to an improper transfer of a resident;
- One intake related to an incident of improper care provided to a resident.

A Complaint Inspection #2021_901759_0008 and Follow-Up Inspection #2021_901759_0010 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Cares (ADOC), Physicians, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Activity Aides, Dietary Manager, Dietary Supervisor, Office Manager, DOC Clerk, Support Services Manager, Dietary Aides, Laundry services, Housekeepers, families, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a PSW used safe transferring techniques while transferring a resident using a mechanical lift.

The homes policy titled "Mechanical Lifts" indicated that two trained staff were required at all times when performing a Mechanical Lift.

A PSW transferred a resident using a mechanical lift without assistance from a second staff member. As a result, the resident reported an injury.

Sources: Interviews with a PSW, an ADOC and other relevant staff; the home's investigation notes; a CI report; and the homes policy titled "Mechanical Lifts" last updated August 2017. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members offered residents hand hygiene before and after meal service.

During dining room observations, the Inspector identified that the staff did not offer or encourage residents to perform hand hygiene before or after meal service.

In interviews with five residents, they all stated that they were not offered or encouraged hand hygiene before or after a meal service.

The IPAC Lead stated that residents were to be encouraged to perform hand hygiene before and after meals.

Sources: Dining Room observations, review of the policy titled ”Hand Hygiene” last reviewed June 2021, resident interviews, IPAC lead and other staff member interviews. [s. 229. (4)]

2. The licensee has failed to ensure that a PSW participated in the implementation the IPAC program.

A review of an internal investigation indicated that a PSW had provided care to a resident without the appropriate Personal Protective Equipment (PPE). It was also identified that the PSW did not perform hand washing after providing the care to the resident.

A review of the home’s policy titled “Point of Care Assessment Algorithm” from the IPAC program, indicated that “staff were to wear gloves and perform hand hygiene when hands would be exposed to blood, excretions, secretions or contaminated items”.

In an interview with the DOC, they verified that the PSW had provided care to a resident without wearing gloves and performing hand hygiene. This action would increase the risk of infection for other residents and staff members.

Sources: The IPAC program; the policy titled "Point of Care Assessment Algorithm" last reviewed January 2021; a CI report, review of the internal investigations, interview with the DOC and other staff members. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's rights to be treated with courtesy and respect were fully recognized.

An incident occurred where a PSW did not provide care to a resident with courtesy and respect.

In an interview with an ADOC and the DOC, they stated that in their internal investigation of the incident, a PSW was not courteous or respectful to a resident while providing personal care which compromised the resident's dignity.

Sources: A CI report, the home's internal investigation, review of the resident's health care records, interview with the DOC and other staff members. [s 3 (1) 1] [s. 3. (1) 1.]

Issued on this 27th day of October, 2021

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

Original report signed by the inspector.