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 August 24, 2022
Inspection Number 2022_1115_0002
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 York, Sudbury

Lead Inspector
Steven Naccarato (#744)

Inspector Digital Signature
Steven C Naccarato
Digitally signed by Steven C Naccarato
Date: 2022.08.25 09:46:57 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 10-12, 15-16, 18, 2022.

The following intakes were inspected:

- One intake related to Compliance Order (CO) #001 that was issued in report #2022_1115_0001, on June 3, 2022, related to care not provided to the resident as specified in the plan of care, with a compliance due date (CDD) of July 15, 2022;
- One intake related to alleged staff to resident neglect; and,
- One intake related to alleged staff to resident physical abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
FLTCA, 2021	s. 6 (7)	#2022_1115_0001	#001	744

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

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

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home related to COVID-19 self- assessment audits, was complied with.

Rationale and Summary
The Minister's Directive: COVID-19 response measures for long-term care homes, identified that licensees shall ensure the development and implementation of a COVID-19 Outbreak Preparedness Plan which must include conducting regular IPAC audits in accordance with the "COVID-19 Guidance Document for Long-term Care Homes in Ontario".

At minimum, homes must include in their audit the PHO's "COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes". Results of the IPAC audit was to be kept for at least 30 days.

The PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes had not been completed by the home prior to the tool being requested by the Inspector. Although the home had conducted other IPAC audits, it did not satisfy all the areas the PHO audit tool required to be audited.

The required COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes was completed by the home during the inspection and supplied to the Inspector prior to the conclusion of the inspection.

There was no impact and low risk to the residents, at the time of the non-compliance, when the home had not completed the COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022; COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated June 28, 2022; Interviews with the DOC and other staff.

Date Remedy Implemented: August 16, 2022 [744]

WRITTEN NOTIFICATION - RESIDENTS' BILL OF RIGHTS

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

Non-compliance with: LTCHA, 2007 s. 3 (1) 1

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Rationale and Summary
An incident occurred where a staff member did not treat a resident with courtesy and respect.

There was moderate harm to the resident.

Sources: The critical incident (CI); the home's investigation notes; the resident's health care records; Interviews with the Administrator and other staff.

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