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 8, 2023	
Inspection Number: 2023-1115-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare York, Sudbury	
Lead Inspector Jennifer Lauricella (542)	**Inspector Digital Signature** Jennifer Lauricella Digitally signed by Jennifer Lauricella Date: 2023.05.11 09:45:50 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13 – 15 and March 20 – 22, 2023

The following intake(s) were inspected:

- One intake related to a residents' death;
- One intake related to a medication incident with adverse reaction to a resident;
- One intake related to alleged abuse and a medication incident;
- One intake related to medication administration and
  Two intakes related to an incident that caused injuries to a resident.

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

Resident Care and Support Services
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5): an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the residents' health condition.

A Critical Incident (CI) report was submitted to the Director on a specific day in February 2023, for an incident that occurred ten days prior. It was documented that a resident was found to have received an extensive injury requiring them to be transferred to the hospital.

A review of the residents' health care records identified that they returned to the home with new orders for medication and treatment plans.

Sources: CIS report; Complaint intake; resident progress notes, Medication Administration Records, skin assessments, physician's order documents, care plan and home's internal incident report and interviews with the POA.
[542]

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A review of the residents' health care record identified that they received two medications in error and subsequently required to be transferred to the hospital.

The home's investigation file was reviewed. It was documented that a RPN had not completed the medication administration checks to ensure that the right medication was provided to the right resident.

The medication error caused a moderate risk to the resident.

Sources: CIS report; medication error records for the home; the residents' health care records, progress notes; home's investigation file and interview with the DOC.

[542]

COMPLIANCE ORDER CO #001 Safe and Secure Home

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) Develop and implement an auditing process to ensure all bed systems are positioned safely in resident rooms. Documentation of the auditing process and audits must be maintained. At a minimum, audits must be completed once per week for at least 6 weeks.

If concerns are identified during the auditing process, implement corrective action that addresses the root cause of the concern and,

2) Implement a process for ensuring that a specified device in resident rooms cannot be adjusted by residents or other individuals visiting the home.

Grounds

The licensee has failed to ensure that the home was a safe and secure environment for the resident.

The resident was found to have received an injury that resulted in them to be transferred to the hospital for further assessment.

Interviews with three different staff members, who all worked when the injury occurred, concluded that the resident was positioned unsafely in their room.

By the home allowing the resident to be unsafely positioned in their room caused them to sustain an injury.

Sources: CIS report; Complaint intake; the residents' progress notes, Medication Administration Records, skin assessments, physician's order documents, care plan and home's internal incident report; interviews with staff and the POA.
[542]

This order must be complied with by June 16, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.