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

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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
Feb 18, 2022	2022_989744_0002	000894-22, 001535-22	Complaint

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

STEVEN NACCARATO (744)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 1-3, 2022.

The following intakes were inspected upon during this Complaint inspection:

-One intake relating to a fall that resulted in an injury; and
-One intake relating to resident care and building maintenance concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager, Infection Prevention and Control (IPAC) lead, Support services Manager, Registered Nurses (RNs), Personal Support Workers (PSWs), Housekeeping staff, and residents.

The Inspector(s) also conducted a daily tour of the resident care areas, observed the delivery of resident care and services, staff to resident interactions, Infection Prevention and Control (IPAC) practices, reviewed residents' health records, internal investigations and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 staff used safe transferring devices and techniques when assisting a resident.

A resident had an unwitnessed fall and was manually assisted to a standing position without the assessment of a registered staff member. A Registered Nurse (RN) indicated that it was unsafe to transfer a resident who sustained a fall, without an assessment from a registered staff member. The RN further indicated that a mechanical lift was required to safely lift the resident after their assessment was completed.

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

Sources: The home’s internal investigation notes; The home’s Falls Prevention and Management Program, last updated December 2020; Interviews with a RN and other staff. [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 devices and techniques when assisting residents, to be implemented voluntarily.

Issued on this 28th day of February, 2022

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

Original report signed by the inspector.