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: August 8, 2024

Inspection Number: 2024-1115-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare York, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-19, 2024
The inspection occurred offsite on the following date(s): July 22-23, 2024

The following intake(s) were inspected:

- One Intake was related to disease outbreak.
- Five Intakes were complaints related to allegations of improper/incompetent care.
- One Intake was related to Improper/incompetent care of residents by staff.
- One Intake was related to a fall of resident resulting in injury
- One Intake was related to a hypoglycemic episode of resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services

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Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care set out in the plan of care was provided to a resident, as specified in the plan.

Rationale and Summary:

In review of a resident's progress notes, a note was identified which indicated the resident had requested specific care being provided by the staff.

The Director of Care (DOC) confirmed that the home did not follow the residents requested care needs as specified in the plan of care.

Sources: A resident's clinical records; Critical Incident (CI) report; Interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that their dining and snack service ensured food was served at a temperature that was both safe and palatable to the residents.

Rationale and Summary:
The home's policy titled "End Point Food Temperatures" indicates that the cook is to "Take end point cooking temperatures".

It was identified on a specified unit that a meal was not served at the appropriate temperature as required. An interview with staff identified that they have a new process to ensure the meal temperature is taken prior to serving, as required.

Sources: Home's policy titled "End Point Food Temperatures" NC-07-01-12, last reviewed January 2022; Interview with staff.

WRITTEN NOTIFICATION: Administration of Medications

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The Licensee has failed to ensure that a registered staff administered medications to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A Critical Incident (CI) Report was submitted to the Director regarding residents not receiving their prescribed medications at their specified time.

A review of the residents electronic medication administration record (EMAR) indicated they were prescribed certain medications to be administered at a specific time.

In an interview with the DOC, they stated that the registered staff did not administer the specific medications as prescribed to residents.

Sources: Review of the home's Medication Management policy "RC-16-01-07, last reviewed March 2023; and record review of the resident's electronic health record including progress notes, EMAR and paper chart; Interviews with the DOC, ADOC and other staff.

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