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
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 4, 2021	2021_864627_0017	005706-21	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

SYLVIE BYRNES (627)

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): June 21-25, 28-30, 2021. Additional off-site activities were completed on July 2, 2021.

The following intake was completed during this complaint inspection;

- One log related to care concerns.

A Critical Incident System inspection, #2021_864627_0018, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Physician, Service Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Maintenance staff, Housekeeping staff, family members and residents.

The Inspector conducted daily observations of the provision of care to the residents, staff to resident interactions, observed infection prevention and control (IPAC) practices, cooling and air temperature requirements, reviewed relevant health care records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
2 VPC(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A resident sustained a fall whereby it was identified that a specific intervention may have prevented the fall and would be implemented to minimize the risk of further falls.

A review of the resident's care plan identified that the intervention was added on the same day to the resident's care plan by the RPN. During multiple interviews with HCAs and RPNs, they stated that they could not recall the resident having the specific intervention. During an interview the RPN, they stated that they had not implemented the intervention. The RN acknowledged that the fall intervention had not been implemented.

The home's failure to comply with the resident's plan of care caused actual risk, as the resident had further falls after the intervention was identified as required but not implemented.

Sources: Interviews with HCAs, RPNs, RN, DOC, post fall assessments, the resident's progress notes, resident's care plan, home's policy titled " Plan of Care". [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was protected from neglect by the licensee or staff.

Ontario Regulation (O.Reg.) 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident had a change in condition that was not addressed . In separate interviews, the DOC/Physician indicated that additional actions should have been take to address the change in condition.

The home demonstrated a pattern of inaction by not addressing the resident's change in condition.

Sources: interviews with HCAs, RPN, RN, a Physician and DOC. Record review of progress notes and the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", WN #4 of this report.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident sustained a fall on a specific date. A review of the resident's health care record failed to identify a post fall assessment.

The RPN and the DOC acknowledged that a post fall assessment had not been completed for the resident when they fell.

The home's failure to complete a post fall assessment caused actual risk to the resident as root cause analysis, possible prevention measures, follow-up plans and care plan revisions were not addressed.

Sources: Interviews with an RPN, RN and DOC, record review of progress notes, assessment tab in Point Click Care, Post Fall Assessments, home's policy titled "Fall Prevention and Management Program". [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances f the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident had an incident for which they received treatment at the hospital. During multiple interviews, staff reported that the resident complained of increased pain afterward. A review of the resident’s assessments in Point Click Care failed to reveal a completed pain assessment.

The RN acknowledged that a pain assessment had not been completed when the resident complained of pain following their return from the hospital.

The home failed to complete a pain assessment when the resident returned from the hospital and exhibiting increased pain which caused actual harm to the resident.

Sources: Interview with HCAs, RPN, RN, record review: Assessment tabs in Point Click Care, home’s policy titled " Pain Management". [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The Service Manager stated that temperatures were not monitored and documented daily; they were monitored and documented on days when the temperature was above 26 degrees Celcius and when the humidex was high.

The lack of temperature monitoring in the home caused minimal risk to the residents.

Sources: Interview with the Service Manager, record review "Temperature and Humidity Log", home's policy titled, "Preventing Heat-Related Illness". [s. 21. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A resident sustained a fall which caused an alteration to their skin integrity. A review of the resident's assessment failed to identify a skin assessment for the resident.

The RN acknowledged that a wound assessment was not completed when the resident sustained a fall that caused an alteration to their skin integrity.

The home's failure to compete a wound assessment for the resident's wound caused actual risk of harm to the resident.

Sources: Interviews with RPN, RN, record review, resident assessment in point click care, progress notes, Health Science North "ED to LTC Report Form", home's policy titled "Skin and Wound Program: Prevention of Skin Breakdown". [s. 50. (2) (b) (i)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is 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 (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

The licensee has failed to ensure that the Director was immediately informed of a resident’s fall that resulted in an injury to the resident for which the resident was taken to a hospital and that resulted in a significant change in the resident’s condition.

A resident sustained a fall which caused a significant change to their health status, for which they were sent to the hospital for treatment.

A review of the online critical incident system (CIS) reporting site to the Ministry of Long-Term care (MLTC) failed to identify a CIS report for the resident’s fall which caused a significant change.

The DOC agreed that the resident had a significant change in their health status caused by the fall and that it should have been reported to the Director.

The failure of the home to report the resident's fall which caused a significant change to the resident's health to the Director caused no harm to the resident.

Sources: interviews with HCAs, DOC; record review, online Ministry of Long-Term Care (MLTC) critical incident system (CIS) reporting site. [s. 107. (3) 4.]

Issued on this 23rd day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2021_864627_0017
Log No. / No de registre :	005706-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 4, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare York 333 York Street, Sudbury, ON, P3E-5J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Lamirande

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA.

Specifically, the licensee shall;
Develop and implement a process to ensure that interventions identified in residents' post fall assessment that may prevent further falls are implemented.

Grounds / Motifs :

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

A resident sustained a fall whereby it was identified that a specific intervention may have prevented the fall and would be implemented to minimize the risk of further falls.

A review of the resident's care plan identified that the intervention was added on the same day to the resident's care plan by the RPN. During multiple interviews with HCAs and RPNs, they stated that they could not recall the resident having the specific intervention. During an interview the RPN, they stated that they had not implemented the intervention. The RN acknowledged that the fall intervention had not been implemented.

The home's failure to comply with the resident's plan of care caused actual risk, as the resident had further falls after the intervention was identified as required but not implemented.

Sources: Interviews with HCAs, RPNs, RN, DOC, post fall assessments, the resident's progress notes, resident's care plan, home's policy titled " Plan of Care". [s. 6. (7)]

An Order was made by taking the following factors into account;

Severity: There was actual risk of harm to the resident resulting from fall interventions not being implemented;
Scope: The scope for this non-compliance was isolated to resident #001;
Compliance history: In the last 36 months, the licensee has a history of non-compliance to the same subsection, with a VPC issued November 9, 2020, from inspection #2020_638542_0015, WN issued on September 27, 2019 from inspection #2019_657681_0024, VPC issued on January 31, 2019, from inspection 2019_668543_0003.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 03, 2021

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with s. 19 (1) of the LTCHA.

Specifically, the licensee shall:
1) Ensure that residents are screened for the presence, or risk of pain after returning from the hospital, including a visit to the Emergency Department.
2) Re-educate an RN on the home's prevention of abuse and neglect policy with a focus on what consists of neglect of residents in the RN role. The content of the education, the date and time the RN completed the education shall be provided to the Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from neglect by the licensee or staff.

Ontario Regulation (O.Reg.) 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident had a change in condition that was not addressed. In separate interviews, the DOC/Physician indicated that additional actions should have been take to address the change in condition.

The home demonstrated a pattern of inaction by not addressing the resident's change in condition.

Sources: interviews with HCAs, RPN, RN, a Physician and DOC. Record review of progress notes and the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", WN #4 of this report.

An order was made by taking the following factors into account:
Severity: There was actual harm to resident #001;
Scope: The scope of this non-compliance was identified as isolated as it related to one resident;
Compliance history: In the past 36 months, the home had no previous non-compliance under s 19 (1) of the LTCHA
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 03, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of August, 2021

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Sylvie Byrnes

Service Area Office / Bureau régional de services : Sudbury Service Area Office