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: April 3, 2024

Inspection Number: 2024-1115-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare York, Sudbury

Lead Inspector	**Inspector Digital Signature**
Jennifer Lauricella (542)	Jennifer Lauricella Digitally signed by Jennifer Lauricella Date: 2024.04.03 10:06:17 -04'00'

Additional Inspector(s)
Kim Byberg (729)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18, 19, 20, 2024.

The following intake(s) were inspected:

- One intake related, to a Follow-up Compliance Order regarding Infection Prevention and Control,
- One intake, related to staff to resident abuse and
- One intake, related to an outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1115-0006 related to O. Reg. 246/22, s. 102 (9) (a) inspected by Jennifer Lauricella (542)

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A resident required assistance from one staff member for daily personal care and dressing.

On a specific day, there was a concern that the resident had not received assistance with certain aspects of their care by the staff.

The staff member assigned to the resident acknowledged that the resident did not receive the care as per their plan of care in error.

Sources: Review of the resident's care plan, documentation, progress notes, home's investigation notes, education records and employee file, interview with PSW staff and the ADOCs.
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