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

Central West District
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Original Public Report

Report Issue Date: September 26, 2024

Inspection Number: 2024-1332-0004

Inspection Type:
Complaint
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Brampton, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-11, 17-20, 23, 2024

The following intake(s) were inspected:

- Intake #00123089 - complaint regarding wound care
- Intake #00123104 - Follow-up #1 - CO #001/ 2024-1332-0003, FLTCA, 2021 - s. 24 (1) Duty to Protect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1332-0003 related to FLTCA, 2021, s. 24 (1)

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

Skin and Wound Prevention and Management
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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A resident stated they wanted their SDM to be involved and made aware of their plan of care. It was identified that the resident had a new wound, and their SDM was not notified.

By failing to ensure that the resident's SDM was made aware of the resident's new wound, they were not given an opportunity to participate fully in the development

and implementation of the resident's plan of care.

Sources: a resident clinical records; interviews with a resident, a resident's substitute decision maker and staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 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 the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A wound swab was ordered for a resident. This swab was not collected until 10 days later. The results of the swab became available six days later, and showed that the resident had an infection.

The doctor stated that the swab was to be collected the day it was ordered.

By failing to collect the swab as per the resident's plan of care, there was risk that the resident's infection was not treated in a timely manner with the appropriate antibiotic.

Sources: a resident's clinical records; interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident received a skin assessment upon return of the resident from hospital.

Rationale and Summary
When a resident returned from hospital, they did not receive a skin assessment.

A Registered Practical Nurse (RPN) indicated that a head-to-toe assessment was to be completed for residents upon return from the hospital, and one was not completed for the resident upon this return from hospital.

By failing to complete a head-to-toe assessment for a resident upon return from hospital, it put the resident at risk of not having any new skin impairments documented, monitored, or treated.

Sources: a resident's clinical records; Skin and Wound Program: Prevention of Skin Breakdown policy; interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly.

Rationale and Summary
A resident had multiple wounds. Wound assessments completed for them on four different dates were not completed in full.

The Wound Care Nurse indicated that the expectation was the weekly skin assessments for the resident were to be completed in full.

By failing to complete the weekly skin assessments in full, the resident's wounds were at risk of not being effectively monitored.

Sources: a resident's clinical records; interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee has failed to ensure a resident's wound care supplies were readily available at the home as required to treat their wounds.

Rationale and Summary
A resident had a wound dressing order that required a particular supply.

For two days this supply was documented to not be available in the home and was not used for changing the residents wound dressing as ordered.

The Wound Care Nurse stated the supply should have been available in the home.

By failing to have the particular supply readily available in the home, the resident did not have their dressing completed as ordered.

Sources: a resident's clinical records; interview with staff.