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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Public Report

Report Issue Date: December 23, 2024

Inspection Number: 2024-1332-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Brampton, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 13 -15, 19 - 22, and 25 - 27, 2024.
The inspection occurred offsite on the following date(s): November 15, 21, and 26 - 27, 2024.

The following intake(s) were inspected in this Critical Incident inspection:
Intake: #00126974 - fall of a resident resulting in injuries.
Intake: #00128584 - related to improper care.
Intake: #00130850 - related to improper care.

The following intake(s) were inspected in this Complaint inspection:
Intake: #00129373 - concerns related to improper care.

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

Resident Care and Support Services
Infection Prevention and Control
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 the care set out in the plan of care was provided to the residents specified in the plan.

Rationale and Summary
Medication Administration Record (MAR) directed staff to give the supplement three times a day at breakfast, lunch, and dinner.

Resident's clinical records identified that a student administered the supplement to the resident as part of their morning medication pass.

By not following the resident's plans of care, put the resident at risk of harm.

Sources: Resident progress notes, plan of care, MARs, the home's investigation records and interviews with staff.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 11 (1) (a)
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

The licensee has failed to ensure that there was an organized program of nursing services that includes direction for student nurses in the home, was complied with.

In accordance with O. Reg. 246/22, the licensee is required to ensure that student nurses as part of the nursing program are provided with on-site supervision by an instructor/preceptor at all times.

Specifically, staff did not comply with the policy "Clinical Student Placements" RC-01-01-04 last reviewed on November 23, 2024, which stated that students are to be provided with supervision at all times.

Rationale and Summary
A student said they administered the resident's supplement on their own and acknowledged that the preceptor was not present in the room with them.

The Director of Care (DOC) acknowledged that students must always have the preceptor assigned to them physically present when providing care to the resident.

By not having the preceptor supervise the student, put the resident at risk of harm.

Sources: Critical Incident Report, resident's clinical records, a videotape of the incident, the home's policy Clinical Student Placements RC-01-01-04 last reviewed November 2023 and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of improper care resulting in risk of harm was reported immediately to the Director.

Rationale and Summary
A family brought forward an allegation of neglect of a resident

The incident was not reported to the Ministry of Long-Term Care (MLTC) until two days later.

By not immediately reporting the suspicion of improper care, the Director was unable to respond immediately.

Sources: Critical Incident System (CIS) Report, and interview with Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)

Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee failed to ensure that in the case of a system that uses sound to alert staff, it was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary
The RPN stated that the staff were able to mute their pagers.

The ADOC reported that some Personal Support Workers (PSW) have been altering their pager settings from alarm mode to vibration mode.

When the home's resident-to-staff communication was not audible to staff, it created a potential risk that staff may not be alerted when residents require their assistance.

Sources: Record reviews: CIS, observations, interviews with the ADOC, RPN and PSW.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the

resident's responses to interventions are documented.

The licensee failed to ensure that all actions taken regarding a resident under the falls prevention and management program, including assessments, reassessments, interventions, and the resident's responses to these interventions, were documented.

Rationale and Summary
A resident had a fall and Head Injury Routine (HIR) was initiated for 72 hours.

The PSW reported that the resident had a change in behaviour and this was communicated to Registered Nurse (RN).

There was no documentation of the unusual behaviours post-fall.

By failing to document the reassessments, interventions, and the resident's condition, the resident was put at risk of not receiving appropriate and timely care.

Sources: Record review of progress notes, interviews with PSW and the DOC.

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the physician was immediately contacted when there was a change in the resident's condition.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a falls management program to reduce the incidence of falls and the risk of injury

Specifically, the licensee did not comply with the home's policy titled "Neurological Signs/Head Injury Routine", which stated to immediately alert the physician when there is a change in the resident's condition.

Rationale and Summary
A resident had a fall resulting in injuries.

The progress note indicated that the Head Injury Routine (HIR) protocol was initiated as a result of the fall.

The RN's assessment failed to documented a change in the resident's condition and the physician was not called immediately as per the policy. '

By failing to follow the home's head injury routine protocol, appropriate interventions were not taken to address the resident's condition.

Sources: Record review of progress notes, "Neurological Signs/Head Injury Routine " policy, and interview with DOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the fall prevention policy was implemented as outlined on the resident's plan of care.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee falls prevention and management program must provide strategies to mitigate falls.

Specifically, the licensee did not comply with the home's policy titled "Fall Prevention and Management Program", which stated to implement strategies and interventions as outlined on the resident's plan of care

Rationale and Summary
A resident had a fall resulting in injuries.

PSW stated that one of the falls interventions was not implemented properly.

Failure to follow the care set out in the plan of care for resident, lead to the resident sustaining injuries.

Sources: CI, Home's policy titled, "Fall Prevention and Management Program" last reviewed March 2023, interviews with PSW, and DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that resident wounds received immediate treatment and interventions to reduce or relieve their pain.

Rationale and Summary
A resident waited a significant period of time for pain medication.

By not providing immediate intervention to reduce or relieve resident's pain, the resident's discomfort was prolonged impacting their overall well-being.

Sources: Record reviews of progress notes, pain assessment, CIS, and interviews with staff and the resident.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. iii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,

iii. names of staff members who responded or are responding to the incident.

The licensee has failed to ensure the names of staff members who responded to the incident were included in the report to the Director.

Rationale and Summary
A Critical Incident Report was submitted to the Director regarding a resident that had a choking incident.

A PSW and a RPN responded to and were present during the incident. The DOC acknowledged that the PSW and the RPN were not included in the CIS report.

By failing to include all staff involved in the incident in the CIS report, prevented the Director from knowing all the staff involved in the incident.

Sources: CIS, the home's investigation records, and interviews with staff.