Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: 2023-06-01	
Inspection Number: 2023-1343-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Hamilton, Hamilton	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature**
Additional Inspector(s) Emma Volpatti (740883)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 14, 17, 18, 19,20, 21, 24, 25, 2023

The following intake(s) were inspected:

- Intake: #00011086 - Complainant with concerns re- Falls prevention and management.
- Intake: #00008924 – Complainant with concerns re: fall prevention, skin and wound care, administration of drugs, cooling requirements and IPAC.
- Intake: #00016301 – [CI: 2858-000026-22] - Neglect of resident.
- Intake: #00021151 – [CI 2858-000003-23] - Resident experienced unresponsive hypoglycemia.
- Intake: #00021359 – Complainant with concerns that resident - Plan of care related to blood glucose management and assessment related to sepsis.
- Intake: #00086162 - Public Complaint with concerns re: accommodation services, staffing and care standards and recreation and social activities.

The following intake(s) were completed:

- Intake: #00002526 - [CI: 2858-000019-22] Fall of resident.
- Intake: #00004188 - [CI: 2858-000014-22] Fall of resident.
- Intake: #00009275 – [CI: 2858-000022-22] - Fall of resident.
- Intake: #00009284 – Complainant with concerns re: plan of care (recurrent UTIs); personal care and falls.
- Intake: #00015998 – [CI: 2858-000024-22] - Fall of resident.

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

Continence Care
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain Management
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care.

Rationale and Summary

A resident's care plan indicated that they required a particular type of lift for care. The transfer and lift assessment completed for the resident indicated that they required a different type of lift for care.

The RAI-Coordinator acknowledged that the transfer and lift assessment should match the care plan, and that they did not ensure that they matched when they completed the assessment.

The DOC confirmed that the transfer and lift assessment is part of the residents written plan of care. The DOC also acknowledged that it gave unclear direction to staff providing care to the resident when the transfer and lift assessment and care plan did not match.

On April 21, 2023, the transfer and lift assessment was updated to reflect the care plan's transfer status for care.

Sources: Interview with the DOC and other staff, resident's clinical record.

Date Remedy Implemented: April 21, 2023

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NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

On April 19, 2023, LTCH inspectors observed the clean linen supply room and dirty linen supply room doors unlocked and open on one of the home areas. There were keypad locks on both of the doors and no staff were in the immediate area.

Two staff acknowledged that the doors should be kept closed and locked at all times. A staff member closed and locked both doors immediately.

There was minimal risk to residents when the supply room doors were left open and unlocked.

Sources: Observations of the Home Areas, interviews with Staff.

Date Remedy Implemented: April 19, 2023

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WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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 resident was noted to have a small bruise on their forehead and was complaining of shoulder pain. Their plan of care indicated they were to have safety checks completed every 30-60 minutes.

The home's investigation notes indicated that the PSW whom had worked the previous night shift did not check the resident every 30-60 minutes.

Failing to implement resident's plan of care led to an increased risk of negative impact to the resident.

Sources: Interview with the DOC, the home's investigation notes, resident's clinical record.

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WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

The licensee has failed to ensure that the pain management program provided assessment instruments for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the pain management program provides for assessment and re-assessment instruments, and is complied with.

Specifically, staff did not comply with the policy "Pain Identification and Management", dated January 2022, which was included in the licensee's Pain Management Program.

Rationale and Summary

A resident had a fall and afterward complained of pain. The resident was then transferred to the hospital. The Resident returned to the home the following day and continued to complain of pain. The resident's clinical record indicated there was no comprehensive pain assessment completed for the resident for that month.

The home's policy titled Pain Identification and Management indicated that a pain assessment must be completed electronically when there is the presence or indication of pain in a resident.

There was a minimal risk posed to the resident when their new onset of pain was not assessed using a comprehensive pain assessment.

Sources: Interview with the DOC and other staff, resident's clinical record, the home's policy titled Pain Identification and Management, last reviewed January 2022.

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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) (b) (ii)

The licensee has failed to ensure that a resident received immediate treatment and interventions to promote healing, and prevent infection of a wound.

Rationale and Summary

A resident returned from the hospital with a skin impairment order. The order was for the dressing to be changed every two days, but the order was not transcribed as per hospital's order. The resident did not receive the dressing change for five days after their initial assessment when they returned from the hospital. The resident's condition worsened, and a new wound order was started.

The resident was at increased risk of infection for not receiving the ordered skin impairment care

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interventions required for healing and infection control.

Sources: Interview with RN, RPN, DOC, Physician's order, Resident' Clinical record.

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WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

A) The licensee has failed to ensure that resident's skin impairment was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident was sent to the hospital and upon return to the home, they had a skin impairment.
The skin impairment was initially assessed and was assessed as healed in five weeks. During that five week period, the skin impairment was reassessed twice. The Physician's order indicated that the skin impairment was to be assessed every Sunday using the Clinical assessment.

Sources: Resident's clinical record, interview with RPN.

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B) The licensee has failed to ensure that a resident's skin impairment was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident was sent to the hospital and upon return to the home, they had a skin impairment. The skin impairment was initially assessed as healed eight weeks later. During that eight week period, the wound was reassessed five times. The Physician's order indicated that the wound was to be assessed every six days using the electronic clinical assessment tool.

Sources: Resident's clinical record, interview with RPN.

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C) The licensee has failed to ensure that a resident's skin impairment was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident was sent to the hospital and upon return to the home seven days later, they had a skin impairment. The skin impairment was initially assessed and was reassessed the following week. There was a gap of thirteen days until the next assessment. There were no further assessments after this and no assessment completed to state that the wound had healed.

Failing to assess the resident's skin impairment at least weekly posed a potential risk of their wounds worsening.

Sources: Resident's clinical record, interview with RPN.

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WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.

The licensee has failed to ensure that the residents were properly monitored during meals.

Rationale and Summary

On two of the units in the home, there were no Registered Staff present in the dining room while residents were having their meal at lunchtime.

On one unit, an RPN was present and was administering medication to the residents in the dining room. Meanwhile, residents on another unit were also having their lunch. The same RPN is responsible for supervising both units during meals.

The RPN acknowledged that there should be a Registered Staff present in the dining room during meals while residents are eating.

Residents’ were at increased safety risk for not receiving proper monitoring in the dining room during meals which is required for their safety.

Sources: Observation, Interview with RPN, DOC

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WRITTEN NOTIFICATION: Laundry Service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)

The licensee failed to ensure that there was a sufficient supply of clean linen, face cloths and bath towels available in the home for use by residents.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint regarding a shortage of clean linen supplies in the home.

Observations of resident rooms and clean linen supply rooms were made throughout the home. One afternoon, there were no clean towels observed in two of the six home areas and less than five towels observed in three of the six home areas. One morning, there were no towels of any kind in the one home area's clean linen supply room, and two of the five resident rooms observed, had one hand towel present. The emergency supply room for linens and towels indicated that there was no emergency supply of any type of towel in the LTCH.

Two Personal Support Workers (PSWs) indicated there had been a shortage of clean linen and towels in the home, and that to provide care for the residents, they either need to go to other home areas to find clean linen and/or towels or go to the main laundry room. One PSW stated at times they use paper towel or toilet paper to provide care.

Laundry Aide indicated that all the laundry aides kept track of how much linen was going up to the floors by documenting a log every day. Review of the linen quota log for the month of April 2023, indicated that on 17 days, they were under quota for one or more types of towels being sent to each home area..

Failing to ensure there was sufficient clean linen, face towels and bath towels available to residents posed risk for residents to receive inadequate care.

Sources: Interview with DOC, Administrator and other staff, observations of the LTCH, interview with resident interview, the home's policy titled Linen Quota, last revised January 2022.

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WRITTEN NOTIFICATION: Administration of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that, medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A high alert medication was ordered to be given to a resident with meals, but the medication was administered earlier than the scheduled time. This resulted in the resident experiencing an unresponsive episode and had to be sent to the hospital.

An RPN stated that the medication should be given after the resident eats and giving the medication before meals can cause their sugar to go too low and that is a danger for the resident.

Another RPN acknowledged that the medication is administered during meals when the resident starts to eat and if you give the medication prior to the resident eating, the resident can fall into hypoglycemic shock.

Not following the directions for administering medication as specified by the prescriber, impacted the resident, and resulted in a critical incident to the resident.

Sources: Interview with RN, RPN, DOC, Resident's Clinical record

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