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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 10, 2023

Inspection Number: 2023-1328-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Lakefield, Lakefield

Lead Inspector	**Inspector Digital Signature**
Kelly Burns (000722)	Kelly Burns Digitally signed by Kelly Burns Date: 2023.05.12 09:53:58 -04'00'

Additional Inspector(s)
Amy Bushey (000746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 5, 11, 12, 13, 17, 18, 2023; and off-site on April 14, 2023.

The following intake(s) were inspected:

- Four (4) intakes related to resident to resident abuse.
- One (1) intake related to a compliant, regarding admission into LTCH, access to a resident, and financial decisions.
- One (1) intake related to a complaint, regarding a resident's responsive behaviours.

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

1) The licensee failed to ensure the Director was immediately notified of alleged abuse that resulted in harm towards a resident by a co-resident.

Pursuant to O. Reg. 246/22, s. 2 (1) for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by a resident that, causes physical injury to another resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident.

Review of a resident's progress notes identified that another incident of abuse had occurred and the allegation of abuse was not reported to the Director. The resident reported to an RPN that a co-resident had abused them and the RPN documented the incident. The RPN confirmed that the resident was injured and appeared upset. The RPN indicated that the resident was immediately assessed, had an injury and the resident complained of discomfort which required medication. The DOC confirmed that the alleged abuse towards a resident by a co-resident had not been reported to the Director. DOC confirmed that the alleged abuse incident should have been reported.

Failure of the licensee to immediately report alleged, suspected or witnessed abuse posed a potential risk to residents.

Source: Review of a CIR, a resident's clinical health record, and interviews with staff. [0007222]

2) The licensee failed to ensure that an alleged incident of abuse towards a resident by a co-resident was immediately reported to the Director.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident.

Pursuant to O. Reg. 246/22, s. 2 (1) for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During the inspection of the CIR, the clinical health record for a resident was reviewed and identified that a co-resident reported being upset that a resident had allegedly abused them.

The Administrator indicated the alleged abuse incident had not been reported to the Director. The Administrator indicated it was their belief they could investigate allegations of abuse prior to reporting incidents to the Director. The Administrator indicated the incident was not reported as it was believed to be unfounded following their investigation. The Director of Care (DOC) confirmed the alleged abuse should have been immediately reported to the Director.

Failure of the licensee to immediately report alleged, suspected or witness abuse of a resident placed the resident at risk of further harm.

Source: Review of a CIR, clinical health records for two residents, and interviews with staff. [000722]

3) The licensee failed to ensure the Director was immediately notified of an alleged abuse towards a resident by a co-resident.

Pursuant to O. Reg. 246/22, s. 2 (1) for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by a resident that, causes physical injury to another resident.

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident. The incident occurred the day prior and resulted in an injury to a resident.

The clinical health record for a resident was reviewed. A Registered Practical Nurse (RPN) assessed the resident following the alleged abuse. The RPN documented that the resident was injured by the co-

resident. The RPN indicated that the Director of Care (DOC) was notified of the alleged incident. The Registered Nurse (RN) indicated the Ministry's after-hours line was not immediately contacted, as there had been no visible injury to the resident, but indicated the resident had voiced being fearful of the co-resident. The RN indicated the complainant voiced safety concerns for the resident. The RN indicated the police were notified of the incident and confirmed the alleged abuse was not immediately reported to the Director.

The complainant and SDM for the resident indicated they received a phone call from the RN, the day of the alleged incident. The SDM indicated they had spoken to the resident who had indicated being abused by the co-resident. The SDM indicated at the time of the phone call, the resident was complaining of discomfort and voiced fear of the co-resident. The complainant visited the resident the next day, and discovered injury to the resident. The complainant indicated that the injury was reported to registered nursing staff at the time of the visit.

The DOC indicated the Director was not immediately notified of the alleged abuse until the following day, as the resident had no visible injury at the time of the incident.

Failure of licensee to not immediately notify the Director of an alleged abuse of a resident, until a injury appears, results in the potential failure to recognize abuse of a resident and the risk of harm to resident.

Source: Review of a resident's clinical health record, a CIR, and interviews with the resident, Complainant, SDM, and staff. [000722]

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)

1) The licensee failed to ensure that the care set out in the plan of care, to safeguard a resident, was provided as planned.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident.

According to the CIR and review of a resident's clinical health record, staff heard a co-resident exhibiting

a responsive behaviour towards a resident; staff arrived to the room and observed the co-resident abusing a resident. Four staff were needed to separate the co-resident from the resident. Staff interviews and record review identified there has been numerous incidents of altercations between the two residents.

The written care plan, specifically related to safeguards in place to protect the resident from the co-resident were identified. Observations failed to identify that planned interventions to safeguard the resident were being utilized.

Registered nursing staff indicated planned safeguard intervention were currently in place for the resident. Registered nursing staff indicated that the interventions were to alert staff if the co-resident entered the resident's room. A PSW and registered nursing staff indicated that the resident had identified interventions in place, but indicated that another planned safeguard intervention had not been in use for the resident. The DOC indicated that written care plan for the resident directs that specific safeguard interventions were to be in place for the resident and confirmed that one of the interventions had not been in place during the inspection.

Failure of the licensee to ensure interventions were in place as planned, to safeguard the resident by a co-resident, placed the resident at further risk of harm.

Sources: Review of a CIR, a resident's clinical health record, and interviews with staff. [000722]

2) 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, specifically interventions to ensure safety and security of the resident, by a co-resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident. The incident occurred the day prior, and resulted in an injury to the resident.

A resident wandered into a co-resident's room resulting in an alleged abuse incident. The incident resulted in an injury to the resident; the resident voiced discomfort resulting from the injury and reported being fearful of the co-resident.

Signage on the resident door directed staff and others to ensure an identified intervention was in place at all times. The resident's written care plan identified safeguards to be in place to protect the resident

from other residents entering their resident. Observations, during this inspection, failed to identify that planned safeguard interventions were in place to protect the resident from others.

An RN indicated they were not aware of a specific safeguard being in use for the resident. Other registered nursing staff and the Director of Care (DOC) indicated that identified safeguard interventions were to be always place for the resident. The staff indicated that the identified safeguards were to be in place to deter a co-resident and others from entering the resident's room. Registered nursing staff indicated that the resident was fearful of residents entering their room, especially one specific co-resident.

Failure to implement safety and security measures for the resident placed the resident at risk of further harm.

Sources: Review of a CIR, clinical health record for a resident, observations of a resident, and interviews with the Complainant, an SDM and staff. [000722

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022 (IPAC Standard) 6.1. The licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care, which may be in place.

Rationale and Summary

The signage on three resident bedroom doors identified they were under infection precautions. The progress notes and the Clinical Care Coordinator (CCC) confirmed the residents had symptoms of infection and results of testing were still pending for two of the residents. The Personal Protective

Equipment (PPE) supply located outside of the residents' rooms did not contain required PPE. The CCC and the review of the licensee's policy confirmed staff were directed to wear the required PPE when entering a resident's room that required the infection precautions, and further confirmed that the PPE had not been available for use.

Failing to ensure the proper donning and doffing of PPE supply was available for staff when caring for residents that required additional precautions placed the residents at potential risk of transmission for infection.

Sources: Review of clinical health records and observations of bedroom doors for three residents, licensee's policy, and interviews with staff. [000722]

2) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), Additional Requirement section 5.4 (g) directs the licensee to ensure that the policies and procedures for the IPAC program also address IPAC related practices for aerosol generating medical procedures (AGMPs).

The licensee's policy directed staff to use a fit-tested N95 respirators (or equivalent) as a minimum level of respiratory protective equipment as well as goggles for eye protection.

Rationale and Summary

A resident was identified to use a medical procedure which was prescribed for them. Signage on the resident's bedroom door indicated they required the medical therapy. The PPE supply located outside of the resident's room did not contain required PPE and hand sanitizer. Staff reported they were not required to change their face mask following care of the resident while the medical therapy was in use. The CCC and the Director of Care (DOC) indicated the resident was not under a specific infection precaution and indicated that staff did not need to doff the mask after assisting the resident with the medical therapy.

The Public Health (PH) Inspector confirmed that the medical therapy was a medical procedure, and signage should be posted at the door of the room to identify the medical therapy was in use. The PH Inspector indicated that staff and others should be wearing appropriate PPE when the medical therapy was in use, including a test fitted N95 mask, face shield, and gown.

Failing to follow the licensee's policies that address IPAC related practices for medical procedure, posed a risk to staff and residents from possible transmission of infections.

Sources: Review of a resident's clinical health records, licensee's policy, observation of resident's bedroom door, interviews with staff and the PH Inspector. [000722]

3) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), additional requirements under the standard 10.1, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% alcohol-based hand rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary

While conducting a tour of the home the Inspector noted the dates of a few alcohol-based hand sanitizers were expired, which included rooms of residents that required additional precautions. The Director of Care (DOC) and the Clinical Care Coordinator (CCC) confirmed the hand sanitizers had expired and needed to be replaced.

Failing to remove expired alcohol-based hand sanitizer increased the risk of infection transmission in the home.

Sources: Observations in a home area, and interviews with staff. [000722]

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

1) The licensee failed to ensure that a resident's substitute decision maker (SDM) was immediately notified of an alleged abuse incident, which resulted in injury and discomfort to the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse toward a resident by a co-resident.

Review of a resident's clinical health record identified that another incident of resident to resident alleged abuse had occurred. A resident had reported to the RPN that a co-resident had abused them. The RPN confirmed that the resident was injured, appeared upset and complained of discomfort which required medication. The RPN indicated they did not notify the resident's SDM at the time of the incident. The documentation indicated the resident's SDM was notified two days later. The DOC confirmed that the alleged abuse of the resident by co-resident had not been immediately reported to the resident's SDM.

Failure to notify residents SDM of injury poses risk, specifically support for the resident and or failure of the SDM to be involved in decisions specific to the resident.

Sources: Review of a resident's clinical health record, and interviews with staff. [000722]

2) The licensee failed to ensure that a resident's substitute decision maker (SDM) was immediately notified of an alleged abuse incident, which resulted in distress to the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident.

Review of a resident's clinical health record identified that another incident of resident to resident abuse had occurred prior to the CIR. The clinical health record for the resident identified that a co-resident was extremely upset following the interaction with the resident. The health record indicated that co-resident was upset and refused to settle; the following day the co-resident requested their family be contacted regarding incident.

The Administrator confirmed awareness of the alleged abuse towards a resident by a co-resident. The Administrator indicated awareness that the resident was upset following the alleged incident. The Administrator confirmed that the resident's SDM was not immediately notified of the incident.

Failure to notify the resident's SDM of alleged, suspected or witnessed abuse decreases supports available to the resident following an abuse incident and prevents the SDM from being immediately involved in investigation and care decisions.

Source: Review of a CIR, the clinical health records for two residents, and interviews with staff. [00072

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)

1) The licensee failed to ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber.

The licensee's policy directed to observe medication ingestion otherwise it cannot be considered administered; and do not leave medication unattended for the resident to self-administer unless the resident performs self-medication administration in adherence with policy.

Rationale and Summary

During the initial tour, a resident was observed with medications in a cup that had been placed on the table in front of the resident. A co-resident was sitting with the resident, and other residents were observed wandering around in the room. A Registered Practical Nurse (RPN) was not within view of the resident. The medication had been signed as being administered by the RPN, on the electronic medication administration record (eMAR). The physician orders reviewed confirmed the medications were prescribed for the resident and did not indicate the resident could self-administer their medication. An RPN, Director of Care (DOC), the Administrator all confirmed that the resident was not permitted to self-administer medication.

Drugs left unattended pose a risk of residents ingesting drugs not prescribed for them and further risk of adverse effects to other residents.

Source: Observations, review of the resident's clinical health record, licensee policy, and interviews with staff. [000722]

2) The licensee failed to ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber.

Rationale and Summary

During the initial tour, a resident was observed with a medication in a cup that had been placed on the table in front of the resident. Residents were observed wandering around in the room. A Registered Practical Nurse (RPN) was not within view of the resident.

The medication had been signed as being administered by the RPN, on the electronic medication administration record (eMAR). The physician orders reviewed confirmed the medication was prescribed for the resident and did not indicate the resident could self-administer their medication. An RPN, Director of Care (DOC), the Administrator all confirmed that the resident was not permitted to self-administer medication.

Drugs left unattended pose a risk of residents ingesting drugs not prescribed for them and further risk of adverse effects to other residents.

Source: Observations, review of a resident's clinical health record, licensee policy, and interviews with staff. [000722]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 2.

The licensee failed to ensure that the 24-hour care plan identified that a resident exhibited identified responsive behaviours, triggers of the behaviour and safety measures to mitigate risk to others.

Rationale and Summary

A CIR was submitted to the Director regarding alleged abuse towards a resident by co-resident.

The clinical health record identified that a resident was admitted to the long-term care home. The resident's application, admission package and an admission progress note identified that the resident had a history of exhibiting identified responsive behaviours prior to their admission date. The admission care plan identified that the resident had exhibited responsive behaviours prior to admission, but failed to identify behavioural triggers, or safety measures to mitigate potential risk to others. Safety measures to mitigate the potential risk to others were not included in resident's care plan until approximately two months later.

The Director of Care (DOC) and registered nursing staff confirmed that the resident's application, admission package, and an admission progress note identified that the resident exhibited the identified responsive behaviour prior to admission. Registered nursing staff confirmed that behavioural triggers and safety measures to mitigate risk to others were not identified in the resident's 24-hour care plan.

Failure to identify behavioural triggers and safety measures, for a resident known to exhibit responsive behaviours, placed residents and others at risk of potential harm.

Source: Review of a CIR, a resident's clinical health record, and interviews with staff. [000722]

WRITTEN NOTIFICATION: Personal items and personal aids

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

The licensee failed to ensure that each resident of the home had their personal Items labelled, specifically for residents residing on one resident home area (RHA).

Rationale and Summary

During the initial tour of the home, Inspectors observed a spa room that had several unlabeled personal items including communal bathing supplies in a cupboard. There were several bins observed in the cupboard containing unlabeled personal items; two of the bins contained personal care items for residents under infection precautions.

The Clinical Care Coordinator (CCC), Director of Care (DOC), and the Administrator all confirmed that all personal care items were to be individually labelled. They further indicated residents were not to share communal bathing supplies. The CCC confirmed that two of the residents were on infection precautions.

Personal care items not labelled for individual usage poses a potential infection control risk, especially noting that some of the care items observed belonged to two residents who required infection precautions.

Source: Observation of one resident home area spa Room, review of two resident's clinical health records, and interviews with staff. [000722]

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

1) The licensee failed to ensure that strategies were developed or implemented, for a resident, who was known to exhibit responsive behaviours towards others.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged abuse towards a resident by a co-resident.

A Resident was known to exhibit a responsive behaviours towards staff and others, prior their admission. Review of the resident's progress notes identified that on an identified date, a co-resident alleged that the resident had abused them. The clinical health record for the resident failed to demonstrate that strategies were developed or implemented, specific to the responsive behaviours exhibited by the resident. Strategies were not developed and implemented until approximately following the alleged abuse incident.

Registered nursing staff and the Director of Care (DOC) all confirmed that strategies had not been developed or implemented for the resident who was known to exhibit responsive behaviours towards other residents before or following the initial abuse incident.

Failure of the licensee to develop and implement strategies related to the exhibited responsive behaviours of the resident placed other residents at risk of harm.

Source: Review of a CIR, the clinical health record for two residents, and interviews with staff. [000722]

2) The licensee failed to ensure that a resident who was known to responsive behaviours had interventions implemented to safeguard other residents.

Rationale and Summary

Critical Incident Reports (CIRs) were submitted to the Director regarding two alleged abuse incidents towards two residents by a co-resident.

A resident was known to exhibit responsive behaviours towards residents. Incidents of alleged abuse towards co-residents by the resident were documented as occurring on three separate occasions. Documentation by registered nursing staff identified that the resident gravitated towards one specific resident. Interventions, in the written care plan for the resident, identified specific safeguard interventions to be in place for the safety of others.

During observations throughout the inspection, the identified safeguards for the safety of other residents were not in place.

A PSW, registered nursing staff and the DOC all indicated that safeguard strategies had been developed and implemented to safeguard co-residents from the resident. An RN and the DOC confirmed that two specific safeguard strategies were not being used, both indicated being unsure why strategies were not in place during the inspection. An RN indicated that the resident remained a risk to co-residents residing in the home.

Failure of the licensee to ensure strategies were implemented for a resident placed other residents at a continued risk of further harm.

Sources: Review of two CIRs, the clinical health records for three residents, observation of the resident, and interviews with staff. [000722]

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee failed to ensure that actions were taken to respond to the needs of a resident who was demonstrating responsive behaviours, including reassessments and interventions.

Rationale and Summary

Critical Incident Reports (CIRs) were submitted to the Director regarding two alleged abuse incidents towards two residents by co-resident, which resulted in an injury.

The resident was known to exhibit responsive behaviours towards co-residents. The resident's written care plan specific interventions to distract and keep the resident away from other residents and to monitor the resident's whereabouts. Documentation by registered nursing staff detail numerous

altercations over several months towards a co-resident by the resident where the interventions were ineffective and not revised.

During one incident, documentation indicated that a co-resident was injured by the resident at which time enhanced monitoring was implemented. Registered nursing staff and the Director of Care (DOC) all confirmed that interventions in place for the resident, including enhanced monitoring remained ineffective.

The clinical health record for the resident failed to demonstrate that interventions were reassessed when strategies had not been effective, specific to exhibited responsive behaviours.

Failure of the licensee to reassess the resident and implement new interventions when strategies to manage the resident's responsive behaviours were ineffective, placed other residents at risk of harm.

Source: Review of two CIRs, the clinical health record for three residents, and interviews with staff. [000722]

WRITTEN NOTIFICATION: Hazardous substances

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

The licensee has failed to ensure that hazardous substances at the home were kept inaccessible to residents.

Rationale and Summary

An unsupervised cart containing hazardous substances was observed in a hallway which was accessible to residents, the cart was unlocked. Housekeeper (HSK) returned to the cart and acknowledged that they should have locked the cart while the cart was not within their view.

The Administrator and Director of Care (DOC) confirmed that the cart contained hazardous substances and should not have been accessible to residents. They further indicated staff have been instructed to lock the cart when not being supervised by staff.

Failing to ensure that hazardous substances were always kept inaccessible to residents, could potentially cause harm to a resident, if not handled correctly or if ingested, inhaled or absorbed.

Sources: Observations during the initial tour of the home, specifically an identified room and a cart, review of the material safety data sheets for four hazardous substances, and interviews with staff. [000722]