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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report (A1)

Report Issue Date: February 21, 2023	
Inspection Number: 2022-1171-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Laurier Manor, Gloucester	
Lead Inspector Severn Brown (740785)	**Inspector Digital Signature**
Additional Inspector(s) Karen Buness (720483) Laurie Marshall (742466)	

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect that the legislative reference for non-compliance for Compliance Order #001 has been changed to O.Reg 246/22 s. 123 (2) from O.Reg 246/22 s. 11 (1) (b). The complaint and critical incident inspection 2022-1171-0001 was completed on December 5, 2022.

The Inspection occurred on the following date(s):
November 21-25, 28-30, 2022
December 1-2, 5, 2022

The following intake(s) were inspected:

- Intake: #00001281-[CI: 2665-000022-22] Resident to resident physical altercation.
- Intake: #00001461-[IL: IL-02684-OT] Complainant with concerns regarding alleged neglect.
- Intake: #00001612-[AH: IL-03370-AH/CI: 2665-000027-22] Staff financial abuse of multiple residents.
- Intake: #00003706 Complaint re family visitation.
- Intake: #00004754-[AH: IL-04493-AH/CI: 2665-000030-22] Medication reconciliation error for resident.

- Intake: #00004799-[CI: 2665-000017-22/IL-01486-AH] Fall of resident resulting in injury and a significant change in condition.
- Intake: #00004899-[IL: IL-03672-OT] Resident has multiple care and operational concerns in the home.
- Intake: #00005061-[AH: IL-01618-AH/CI: 2665-000018-22]Unknown cause of injury to resident.
- Intake: #00005585 Complainant had concerns related to a resident's care.
- Intake: #00005921-[AH: IL-04859-AH/CI: 2665-000032-22] Alleged resident to resident sexual abuse.
- Intake: #00006673-[AH: IL-98534-AH/CI: 2665-000007-22] Allegations of staff to resident neglect and emotional abuse.
- Intake: #00007760-[AH: IL-05116-AH/CI: 2665-000033-22] Resident sustained injury of unknown cause.

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

Infection Prevention and Control
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Resident Charges and Trust Accounts
Falls Prevention and Management
Palliative Care
Safe and Secure Home
Medication Management
Resident Care and Support Services
Responsive Behaviours
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident, upon their return from hospital, received a skin assessment by a registered nursing staff member as per the regulations.

Rationale and Summary
When a resident returned to the home from hospital, the registered nurse (RN) receiving the resident stated they could not recall performing a skin assessment..

In interviews with the RN who received the resident, another staff RN, and a Registered Practical Nurse (RPN), it was consistently stated in their interviews that a skin assessment is to be performed on every resident returning from hospital and the assessment is to be documented in the assessments section of the resident's chart.

The interviewed nurses all reviewed the resident's chart and confirmed that no skin assessment was documented. Per the home's policy, all residents are to receive a head-to-toe skin assessment by a registered staff member upon any return from hospital.

Risk/Impact
By not performing skin assessments on residents returning from hospital, residents are placed at increased risk of having unidentified skin integrity impairment.

Sources
Interviews with two RN's and an RPN
Chart review of the resident conducted with the interviewed nurses
The home's skin assessment policy

[740785]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) b.

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control. Specifically, the licensee has failed to implemented section 5.4 (e) of the Infection Prevention and Control Standard for Long Term Care Homes (IPAC Standard).

Rationale/Summary
As per the IPAC Standard section 5.4 (e), the licensee shall ensure that policies and procedures for the hand hygiene program are in place and followed. The home's hand washing procedures states that the home will participate in a provincial or national hand hygiene program as outlined by other related provincial requirements and standards. The home's hand hygiene policy direct staff to encourage and/or offer assistance to properly wash or sanitize resident's hands before and after meals or snacks.

According to the Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, dated April 2014 from the Provincial Infectious Diseases Advisory Committee (PIDAC), in the Summary of Recommendations for Best Practices for Hand Hygiene in All Health Care Setting: Recommendation 10 is to "use 70 to 90% alcohol-based hand rub for hand hygiene in all health care settings." Recommendation 11. in the Summary of Recommendations for Best Practices for Hand Hygiene in All Health Care Setting is to "wash hands with soap and water if there is visible soiling with dirt, blood, body fluids or other body substances. If hands are visibly soiled and running water is not available, use moistened towelettes to remove the visible soil, followed by alcohol-based hand rub."

Dining room observations found that staff consistently used branded Personal Care Wipes to perform or support resident hand hygiene. A manager stated that staff are to use hand sanitizer wipes for resident hand hygiene. Another manager stated that Personal Care Wipes are placed throughout the home, including dining rooms for resident hand hygiene. In a review of the listed composition of the Personal Care Wipes, no alcohol-based hand sanitizer was listed.

Risk/Impact
By not ensuring hand hygiene is provided to residents in accordance with the IPAC Standard and the PIDAC Best Practice recommendations, residents are placed at increased risk of disease transmission by not having adequate hand hygiene prior to mealtimes.
Sources
Dining Room Observations,
Interviews with two managers
Extendicare Hand Hygiene Policy, Last Reviewed Date: April 2022

Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, April 2014. MLTCIB Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022,
Safety Data Sheet Product Name: 22900 Personal Care Wipe, date: June 26, 2018.

[740785]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale/Summary
A complaint was made by a resident reporting that the hot food was being served cold. The complainant stated this issue was brought to management, but nothing was done to improve the serving temperature of the food. At the time of inspection, a review of Resident Council Meeting Minutes and an interview with another resident confirmed there has been continued complaints made to the home by the residents related to the food temperatures.

The home's Temperatures of Food at Point of Service Policy states dietary staff shall serve food and beverages to each resident at a temperature and in a manner that promotes comfort and safety.

An interview with a dietary aide and a manager confirmed staff are directed to take the food temperatures prior to serving food to the residents. The dietary aid reported food temperatures are recorded on food temperature log sheets.

A review of multiple weeks of food temperature logs on several floors revealed that the food temperatures at point of service were not taken for numerous meal services. The temperature logs were also not completed in full, with multiple incidents of missing dates and incorrect dates.

Risk/Impact
As per the Resident's Bill of Rights, all residents have the right to an optimal quality of life. Failure to ensure the residents receive food at safe and palatable temperatures puts the residents at risk for food-borne illness and decreased quality of life.

Sources:
Resident Council Minutes.
Temperatures at Point of Service Policy (last reviewed January 2022)/
Temperature Food Logs.
Interviews with two residents, a dietary aide, and a manager.

[720483]

COMPLIANCE ORDER CO #001: Medication Management System

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 123 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O.Reg 246/22, s. 123 (2).

Specifically, the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. In accordance with O. Reg 246/22 s. 11 (1) b, the licensee shall ensure that this policy is complied with.

To ensure compliance with the medication management system, medication reconciliation policy, the licensee shall develop and implement the following monitoring and remedial processes:

A) Ensure adherence to the medication reconciliation policies and procedures by completing audits, on a weekly basis for a period of four consecutive weeks, on any new resident admission on all units. If the home does not admit a new resident during a week prior to the compliance due date, it must select and audit the adherence to medication reconciliation policies and procedures for at least one, and up to two re-admitted residents on all units during that week. These audits will ensure the correct implementation of the medication reconciliation policy and procedures for:

- Any newly written medication prescription by a physician or nurse practitioner,
- Reconciliation of any new medication prescription in the Electronic Medication Administration Record (eMAR),
- The receipt of the medication from pharmacy,

- The administration of the medication/treatment to the new resident admission and selected re-admitted residents.

B) The licensee shall ensure that corrective action is taken if deviations from the established policies and procedures are identified in their audits.

C) That the two Registered Practical Nurses and Registered Nurse (RN) involved in the incident, if on or returning to active duty with the home, receive training regarding medication reconciliation for newly admitted or re-admitted residents.

D) A written record must be kept of everything required under (A), (B), and (C).

Grounds

Non-compliance with: O. Reg 246/22 s. 123 (2).

The licensee failed to ensure that the Medication Reconciliation Policy, as part of the Medication Management program, to accurately reconcile medication for the resident was complied with upon their admission.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to develop a medication management system that ensures the safe provision of medication management and optimizes effective drug therapy outcomes for residents, and that it is complied with.

Specifically, two RPNs and an RN did not comply with the policy “Medication Reconciliation” dated January 2022, which was included in the licensee’s Medication Management Program.

During the new admission of a resident, an RN incorrectly wrote the resident’s medication order while transcribing the order. Subsequently, during the review of the newly admitted resident’s medication orders in the home’s paper and electronic chart, two RPNs and another RN did not review the original source of the resident’s medication order, only reviewing the incorrectly worded order in the resident’s paper chart against what was written in the resident’s electronic medication record.

The home’s policy for medication reconciliation states that the nurses reviewing the chart, to ensure accurate transcription of medication orders, must review and compare the original source(s) of the medication order to what has been written in the resident’s paper and electronic chart.

Interviews with the Director of Care and an RN both confirmed that the nurses performing the review of the resident’s medication in the resident’s paper and electronic chart did not compare what was written in the home’s charts to the original source of the medication order from outside the home. The Director of Care and two RNs also stated that, in general, when reviewing written orders for newly admitted or re-admitted residents, that the nurse performing the review must compare the order written in the chart against the original source of the order.

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Risk/Impact

By not comparing and reconciling the medication order as written in the home's chart against the original source of the medication order, the medication transcription error written in the home's charting went unnoticed. This error caused the incorrect administration of the resident's medication, causing them to be admitted to hospital. Comparing the written medication order against the original source of the order would likely have caught the original transcription error, likely preventing the resident from enduring a hospital admission.

Compliance Due Date

February 17, 2023

Sources

Interviews with the Director of Care and two RNs
Internal Medication Error Follow Up investigation notes.
Medication Reconciliation policy, last revised January 2022.
The resident's health records

[740785]

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this Order in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this this Order pending the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this Order is deemed to be confirmed by the Director and, for the

purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.