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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 26, 2022
Inspection Number 2022_1093_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare Medex, Ottawa

Lead Inspector
Susan Lui (178)

Inspector Digital Signature
Susan Lui
Digitally signed by Susan Lui
Date: 2022.09.07 09:38:22 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 7-8, 12-15, 18-22, 2022

The following intake(s) were inspected:

- Intake #006634-22 (CIS #2579-000006-22) related to a fall that caused injury and required a transfer to hospital.
- Intake # 007312-22 and Intake #007562-22 (Complaints) related to falls.

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

- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24(1)(2)

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm to a resident has occurred, did immediately report the suspicion and the information upon which it is based to the Director under the Long-Term Care Homes Act (LTCHA).

Rationale and Summary

A resident shook a second resident, which caused the second resident to fall and sustain minor injuries. The incident was not reported to the Ministry of Long-Term Care as required. The Director of Care (DOC) indicated that the nurse on duty should have used the Ministry Decision Tree to determine that this was a mandatory reporting situation, reported the incident to the Ministry of Long-Term Care via the After Hours line, and to a manager in the long-term care home who would then submit a Critical Incident report.

The RN who was on duty at the time of the incident indicated that they should have reported the incident to the Ministry of Long-Term Care, as it constituted resident to resident abuse. The RN could not explain why they did not report the incident at the time.

Sources: Interviews with an RN and the DOC; Clinical health record for a resident.

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COMPLIANCE ORDER [CO#001] FALLS PREVENTION AND MANAGEMNT

NC#02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 s. 48(1)1

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10, s. 48(1)1.

The licensee shall:
1) Perform weekly audits to ensure that staff are following the licensee's falls prevention and management policies with regards to:
- Performing a Fall Risk Assessment on all residents on admission and for any fall with serious injury, and for residents with multiple falls.
-Completing a post-fall assessment after every resident fall, using the licensee's Post-Fall Assessment Tool.

The audits are to be conducted until consistent compliance to the licensee's falls prevention policies described above is demonstrated.

2) Take corrective actions to address staff non-compliance to the licensee's fall prevention policies identified in the audits.

Records of the audits and corrective actions taken to address staff non-compliance to the licensee's falls prevention and management policies shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

Non-compliance with: O. Reg. 79/10, *s. 48(1)1*

The licensee has failed to comply with their Falls Prevention and Management Program.

In accordance with O. Reg. 79/10, s. 48 (1)1, the licensee is required to ensure there is a falls prevention and management program in place, and in accordance with O. Reg 79/10 s. 8 (1) b, the licensee must ensure the program is complied with.
Specifically, staff did not comply with the Falls Prevention and Management Program policy, dated most recent review January 2022.

Rationale and Summary
A resident fell four times in approximately nine weeks. On their last fall the resident sustained a serious injury requiring transfer to hospital and returned to the home for end of life care. The resident died ten days after the fall.

The licensee's written Falls Prevention and Management Program policy indicated that all residents are to be screened using the Fall Risk Assessment Tool on admission, after any fall with serious injury, and for a resident with multiple falls, as appropriate. The policy further indicated that after a resident falls the nurse is to complete a post-fall assessment using the Post-Fall Assessment Tool.

A fall risk assessment was not conducted for the resident using the Fall Risk Assessment Tool on admission or after any of their falls, including their last fall which caused serious injury. Further, a post fall assessment was not conducted using the Post Fall Assessment Tool after the resident's last fall.

This non-compliance increased the risk of harm to the resident because use of the fall risk assessment tool may have assisted staff to better identify the causes of the resident's potential fall risks and thereby develop more effective fall prevention measures for the resident.

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Sources: Interviews with the DOC and other staff; Clinical health record for a resident; Policy "Falls Prevention and Management Program" dated last reviewed January 2022.

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This order must be complied with by October 31, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of 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 or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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(these) Order(s) is(are) and/or this AMP 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.