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

Ottawa District
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Original Public Report

Report Issue Date: April 26, 2023

Inspection Number: 2023-1093-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Medex, Ottawa

Lead Inspector	**Inspector Digital Signature**
Anandraj Natarajan (573)	Anandraj Natarajan Digitally signed by Anandraj Natarajan Date: 2023.04.26 11:50:19 -04'00'

Additional Inspector(s)
Marko Punzalan (742406)
Martin Orr (000747), present during the inspection as an observer.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 29, 30, 31, 2023 and April 3, 4, 5, 6, 11, 12, 2023 and offsite on April 5, 2023.

The following intake(s) were inspected:
Intake: #00018098 - Complaint/ concerns related to the care of a resident.
Intake: #00022765 - Complaint/ concerns related to the care and services to a resident.
Intake: #00016571 - Allegations of resident to resident physical abuse.
Intake(s): #00016655, #00016795 and #00019400 - related to a missing resident.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
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 (1) (c)

The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident. Specifically, in relation to the resident's transfers.

Rationale & Summary: A resident's Physiotherapy progress notes/ assessment documentation in October 2022, indicated that the resident required type (A) mechanical lift, using a type (A) sling. The resident's PSW daily documentation record for transfers, indicated that the resident required type (A) mechanical lift, using a type (B) sling. The resident's written plan of care for transfers, indicated that the resident required type (B) mechanical lift for transfers.

The Inspector reviewed the resident's written plan of care, in the presence of an RN. Upon review, the RN indicated that the resident's written plan of care did not provide clear directions to staff regarding the resident's transfers and the type of sling. Failure to ensure clear directions in the written plan of care related to the transfer can pose a potential risk of harm to the resident.

Sources: Resident's health care records and interview with the RN and other staffs. [573]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident, so that their transfer sling assessments were integrated, consistent with and complemented each other.

Rationale & Summary: A resident's progress notes documentation in September 2022, indicated that the resident was getting bruises due to the transfer sling and requested a Lift and Transfer re-assessment. The Lift and Transfer assessment documentation by the registered nursing staff, indicated that the resident was on a type (B) mechanical lift for transfers, with type (A) sling. As per the PSW staff, the resident required type (A) mechanical lift and since the type (A) sling was not fitting on the resident, they needed the type (B) sling.

The resident's Physiotherapy progress notes/ assessment documentation in September 2022, indicated that the staff have the option of using the type (A) mechanical lift for the resident. Furthermore, it indicated that the resident does not qualify for the type (B) sling. Another referral was sent to the Registered Physiotherapist to re-assess the resident's transfer status. The resident's Physiotherapy progress notes/ assessment documentation, indicated that the resident required type (A) mechanical lift, using the type (A) sling.

A Registered Nursing staff progress notes documentation in November 2022, indicated that the resident was noted to have type (B) sling for transfers. Furthermore, it indicated that in discussion with the Physiotherapist there was miscommunication between staff about whether to use the type (B) sling. The progress notes indicated that the type (B) sling was removed from the resident's room. The point click care PSW task documentation for the resident's transfers in November 2022, indicated that the resident required type (A) mechanical lift and the staff were to apply the type (B) sling.

The Inspector spoke with Transfers Lift Committee (TLC) staff, they indicated that the residents transfer assessments are completed upon initial admission, quarterly, post fall and when there is a significant change in the residents health status. Furthermore, they stated that they do monthly audits for the residents in the home related to the use of resident's transfer sling. The TLC staff indicated that according to their assessment, the resident required type (A) mechanical lift using the type (B) sling.

The Inspector spoke with the DOC who agreed that the resident's transfer/sling assessment was not integrated and consistent with the staff involved in the different aspects of care to reflect the resident's transfer needs. The staff involved in the different aspects of care not collaborating with each other in the resident's transfer assessments pose a risk of harm to the resident.

Sources: Resident's health care records and interview with the TLC staff, the DOC and other staffs. [573]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary: The Ministry of Long-Term Care received a complaint that the resident's substitute decision maker (SDM) was not given an opportunity to fully participate in the development and implementation of a resident's plan of care.

A review of a resident's health care record identified that the resident had a SDM for their personal care. Furthermore, the records indicated that the resident's SDM was actively involved in the resident's personal care and the LTCH staff communicated with the SDM regarding the resident's health conditions.

An interview with the RN and the ADOC, acknowledged that the resident's SDM was not given an opportunity to fully participate in the development and implementation of the resident's plan of care as it relates to the resident's medication changes and a diagnosis of a respiratory illness. By not notifying the substitute decision-maker they were not able to make informative decisions when participating in the development and implementation of the resident's plan of care.

Sources: Resident's health care records and interview with the RN and ADOC. [573]