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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 5, 2024
Inspection Number: 2024-1093-0004
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Medex, Ottawa

INSPECTION SUMMARY

The inspection occurred on the following date(s): October 24, 25, 28, 31, 2024

The following intake(s) were inspected:

- Intake: #00126171/ Critical Incident System (CIS) #2579-000013-24- related to an incident that caused injury to a resident.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Duty to protect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order in adherence with FLTCA, 2021, s. 155 (1) (a).
The licensee shall:

1) Provide education to all Registered Nurses, Registered Practical Nurses, and Personal Support Workers in full-time or part-time regular positions on the following items:

a. The importance of monitoring residents as per their assessed needs (ie. Hourly rounding).
b. The importance of implementing identified strategies for fall prevention as it relates to toileting and incontinence care by using CIS# 2579-000013-24 as an example.
c. The home's policy on zero tolerance of abuse and neglect including the definition of "Neglect" as found in Ontario Regulations 246/22 s. 7 by using CIS# 2579-000013-24 as an example.

2) Keep a record of the education provided including but not limited to: a brief summary of the education provided, the date(s) of delivery, and names and role of staff in attendance, and the name(s) of who provided the education.

3) Should any staff as mentioned in clause 1) be unable to receive the education as

described, keep a record of staff names and reason for not receiving the education.

Grounds
The licensee has failed to ensure that residents are protected from neglect by the staff.

Ontario Regulations 246/22 define neglect as: "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date and time, a resident experienced a fall resulting in significant injuries. After receiving treatment in hospital, the resident died as a result of the injuries sustained.

The resident's care plan included direction for staff to anticipate needs around incontinence overnight to reduce falls risk. A staff responded to a fall prevention alarm as the resident was agitated and attempting to get out of bed. That staff member requested another staff member to check resident and provide incontinence care as this was a known contributor to agitation for this resident overnight.

Video footage was reviewed as part of an internal investigation to ascertain the movements of the staff while on the shift. It was determined that the resident did not receive incontinence care during the hours leading up to the fall incident on the shift despite the second staff telling the first staff they had completed the care. The video footage also indicated that the staff responsible for rounding on the resident had not completed their tasks as required while on shift prior to the fall incident. The inaction of a staff by not providing care when they said that they had provided it,

jeopardized the health, safety and well-being of the resident. The resident experienced a fall, and later died from their injuries.

Sources: A resident's Care Plan, Interviews with a nurse, interview with the Director of Care, Disciplinary Letter for the staff involved in the incident

This order must be complied with by December 16, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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;
(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

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(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:
(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.