Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the *Long-Term Care Homes Act, 2007*

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 4, 2020 | 2020_714673_0005 | 019881-20 | Critical Incident System |

### Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

### Long-Term Care Home/Foyer de soins de longue durée

Extendicare Mississauga
855 John Watt Boulevard MISSISSAUGA ON L5W 1G2

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BABITHA SHANMUGANANDAPALA (673)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): October 1- 2; and 5-8, 2020.**

**During this inspection, Log #019881-20 (CIS #2884-000010-20) related to an unexpected death was inspected.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Equipment Consultant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.**

**During the course of the inspection, the inspector(s) observed care provided to residents, and reviewed residents' and home's records.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order<br>AMP – Administrative Monetary Penalty | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités<br>AMP – Administrative Monetary Penalty |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>AMP (s) may be issued under section 156.1 of the LTCHA | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.<br><br>AMP (s) may be issued under section 156.1 of the LTCHA |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care was notified of the unexpected death of resident #001 on a specified date by an identified method of self harm.

The resident had a long-standing history of identified illnesses and a previous attempt at self harm by the same identified method.

Approximately two months before the specified date, the resident was noted to have been experiencing a repeated infection which resulted in increased specified symptoms.

The resident experienced acute changes in behaviour and an increase in symptoms eleven days before the specified date.

The resident's plan of care was updated five days before the specified date and interventions included for staff to monitor the resident every half hour using the Dementia Observation System (DOS).

The resident was tested for the infection and the results returned three days before the identified date and showed that they were positive for the infection. The resident was started on treatment for the identified infection one day before their death.
Nursing staff's responsibilities included ensuring they guide and communicate with the PSWs in the care for residents. Nurses were made aware if a resident is on DOS monitoring through verbal report at each shift change, and the Behavioural Supports Ontario (BSO) binder at the nursing station.

a) The charge nurse working the night that the resident died was not aware of the resident's behaviours in the last two weeks, or that they were to be monitored every half hour as it had not been communicated during shift change and they had not read it in the shift report. They were only aware of the treatment that was being implemented for the resident's infection and that the PSW was to inform them if the resident was wandering.

The PSW on the unit that night was aware that the resident had wandering behaviours at night and was to be checked regularly. They had not checked resident #001 every 30

minutes and instead completed rounds to check all residents every hour. They saw the resident at 0030hrs at which time the resident was sleeping, and then once more at a time they could not recall; and after that they became busy with providing care to residents on the other side of the unit. They checked the rooms and noticed that the resident was not in their room. The PSW searched with another PSW for the resident and found them in another resident's room in a state of self-harm at approximately 0300hrs.

This noncompliance is being issued because resident #001 was not monitored every half hour as per their plan of care.

b) The resident's plan of care was updated five days before the specified date and interventions included for staff to increase assistance with personal care related to the recurring infection.

The charge nurse working the night that the resident died was not aware of the level of care required for the resident. They saw the resident at approximately midnight in the washroom independently washing themselves and did not provide assistance.

This noncompliance is being issued because resident #001 was not provided supervision or assistance with continence care as per their plan of care.

Sources: Admission Memo, care plan, BSO care plan document, progress notes, geriatric psychiatry consultation notes, DOS records, electronic medication administration record, RN #105, PSW #106, and other staff. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 12th day of November, 2020**

**Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c.8

**Ministère des Soins de longue durée**

**Order(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de sions de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | BABITHA SHANMUGANANDAPALA (673) |
| **Inspection No. / No de l'inspection :** | 2020_714673_0005 |
| **Log No. / Registre no:** | 019881-20 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Nov 4, 2020 |
| **Licensee / Titulaire de permis :** | Extendicare (Canada) Inc.<br>3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9 |
| **LTC Home / Foyer de SLD :** | Extendicare Mississauga<br>855 John Watt Boulevard, MISSISSAUGA, ON, L5W-1G2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Dolly Kunji |

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to residents as specified in the plan.

The plan must include but is not limited to:

1. Provide additional training to PSW #106 and RN #105 related to plan of care and behavioural interventions including:
- DOS monitoring

2. Provide additional training to RN #105 and all registered nursing staff and personal support workers related to:
- communication required among staff at each shift change to ensure continuity of care including interventions and monitoring for residents who are at risk to themselves or others
- the roles and responsibilities of registered nursing staff including supervision of staff and residents.

3. Maintain a copy of the training material, dates, name of the person most responsible for the training and an attendance record. Conduct post-training testing or evaluation to ensure knowledge comprehension of the training material and maintain evaluation records.

Please submit the written plan for achieving compliance for inspection #2020_714673_0005 to Babitha Shanmuganandapala, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by December5, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care was notified of the unexpected death of resident #001 on a specified date by an identified method of self harm.

The resident had a long-standing history of identified illnesses and a previous

attempt at self harm by the same identified method.

Approximately two months before the specified date, the resident was noted to have been experiencing a repeated infection which resulted in increased specified symptoms.

The resident experienced acute changes in behaviour and an increase in symptoms eleven days before the specified date.

The resident's plan of care was updated five days before the specified date and interventions included for staff to monitor the resident every half hour using the Dementia Observation System (DOS).

The resident was tested for the infection and the results returned three days before the identified date and showed that they were positive for the infection. The resident was started on treatment for the identified infection one day before their death.

Nursing staff's responsibilities included ensuring they guide and communicate with the PSWs in the care for residents. Nurses were made aware if a resident is on DOS monitoring through verbal report at each shift change, and the Behavioural Supports Ontario (BSO) binder at the nursing station.

a) The charge nurse working the night that the resident died was not aware of the resident's behaviours in the last two weeks, or that they were to be monitored every half hour as it had not been communicated during shift change and they had not read it in the shift report. They were only aware of the treatment that was being implemented for the resident's infection and that the PSW was to inform them if the resident was wandering.

The PSW on the unit that night was aware that the resident had wandering behaviours at night and was to be checked regularly. They had not checked resident #001 every 30 minutes and instead completed rounds to check all residents every hour. They saw the resident at 0030hrs at which time the resident was sleeping, and then once more at a time they could not recall; and after that they became busy with providing care to residents on the other side of the unit. They checked the rooms and noticed that the resident was not in their room. The PSW searched with another PSW for the resident and found them in another resident's room in a state of self-harm at approximately 0300hrs.

This noncompliance is being issued because resident #001 was not monitored every half hour as per their plan of care.

b) The resident's plan of care was updated five days before the specified date and interventions included for staff to increase assistance with personal care related to the recurring infection.

The charge nurse working the night that the resident died was not aware of the level of care required for the resident. They saw the resident at approximately midnight in the washroom independently washing themselves and did not provide assistance.

This noncompliance is being issued because resident #001 was not provided supervision or assistance with care as per their plan of care.

A Compliance Order was made by taking the following factors into account:
Severity: A resident engaged in an identified method of self harm resulting in their death. There was serious harm to the resident as the resident was not monitored every 30 minutes as per their plan of care.
Scope: This was an isolated case as no other incidents of the plan of care not being followed were identified during this inspection.
Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) and two Written Notifications (WNs) and two voluntary plans of correction (VPCs) were issued to the home.

Sources: Admission Memo, care plan, BSO care plan document, progress notes, geriatric psychiatry consultation notes, DOS records, electronic medication administration record, RN #105, PSW #106, and other staff. [s. 6. (7)] (673)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 05, 2021

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 4th day of November, 2020**

**Signature of Inspector /**
**Signature de l’inspecteur :**

**Name of Inspector /**
**Nom de l’inspecteur :** Babitha Shanmuganandapala

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office