

Ministry of Long-Term Care

Long-Term Care Operations Division Long-Term Care Inspections Branch Toronto Service Area Office 5700 Yonge Street, 5th Floor Toronto ON M2M 4K5 Telephone: 1-866-311-8002 TorontoSAO.moh@ontario.ca

	Original Public Report
Report Issue DateJune 24, 2022Inspection Number[2022_1369_0001]Inspection Type	
 □ Critical Incident System ⊠ Complaint □ Follow-Up □ Proactive Inspection □ SAO Initiated □ Other	 Director Order Follow-up Post-occupancy
Licensee Extendicare (Canada) Inc. 3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9	
Long-Term Care Home and City Extendicare Mississauga 855 John Watt Boulevard Mississauga ON L5W 1G2	
Lead Inspector Nicole Ranger (189)	Inspector Digital Signature

INSPECTION SUMMARY

The inspection occurred on the following date(s): on- site: May 19, 20, 27, 30, 31, 2022 off- site: June 1, 2022.

The following intake(s) were inspected:

- Intake # 018544-21 (Complaint) related to allegations of neglect, skin and wound care, and nutrition and hydration.
- Intake # 008181-21 (Complaint) related to allegations of neglect, infection prevention and control, personal support services.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Safe and Secure Home



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

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non compliance with: O. Reg 246/22 r. 23 (4)

During observations on an identified home area on May 31, 2022, at 1105 hours, Inspector entered the home area and found the west and east hallways to be extremely hot. A staff member stated that it was hot all morning.

The air temperature log for the home area showed a reading of 27.2 degree Celsius (C). The inspector reviewed additional dates and found from May 30, 2022, 1600 hours to May 31, 2022, 1200 hours, the air temperature reading for two home areas was greater than 26 degrees C.

The Environmental Service Manager reported that the home was currently conducting maintenance service on the air conditioning unit. The service contractor stated that they serviced the air conditioning unit in the identified home area on May 30, 2022, and the air conditioning was repaired on May 31, 2022.

The Administrator indicated that once the indoor temperature reached 26 degrees C, the home should implement their heat related illness prevention and management plan. The Administrator and Environmental Service Manger proceeded to implement portable air conditioning units in the identified hallway and reported no residents were affected or concerns reported.

Source: Observations on an identified home area on May 30, 2022, review of air temperature logs, interview with RPN #115, Administrator, Environmental Service Manager, Service Contractor.

Date Remedy Implemented: May 31, 2022 [189]

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1 Non-compliance with: LTCHA, 2007, s. 6 (4)(b).

The licensee has failed to ensure that staff and others involved in resident #001's plan of care collaborated with each other so that different aspects of care are integrated and are consistent with and complement each other.



Toronto Service Area Office 5700 Yonge Street, 5th Floor Toronto ON M2M 4K5 Telephone: 1-866-311-8002 TorontoSAO.moh@ontario.ca

Rationale and Summary:

A complaint was submitted to the Ministry of Long Term Care (MLTC), that resident #001 was transferred to the hospital from the long-term care home (LTCH), and the resident appeared neglected, lacked nutrition, with multiple skin impairments. The complainant reported they were unsure why the resident had been transferred to the hospital as there was no documentation or history provided by the LTCH.

Resident #001 was deemed palliative on an identified date, after a recent history of decreased fluid intake, difficulty swallowing, and decline in health status. The resident had a history of skin impairment and experienced a recent flare-up for which they were assessed and received prescription skin treatment. Interventions also included hydration therapy, pain medication and nutritional assessment. The resident was later reassessed by the nurse practitioner who contacted the family on an identified date; family agreed to stop interventions. Later that day, another family member visited the resident and requested that the resident be sent to hospital for further assessment. A transfer report was provided to the paramedics; however, a current history of recent change in condition with interventions implemented was not documented on the transfer report.

The Administrator and Assistant Director of Care (ADOC) acknowledged the resident's medical and treatment history, interventions, and family communication should have been included on the transfer report, in collaboration, to ensure that the hospital was aware of the interventions and outcomes provide by the LTCH for continuity of care to the resident.

Sources: Resident #001's, progress notes, nutrition and hydration assessments, interviews with RPN #104, ADOC, Nurse Practitioner, Administrator and complainant. [189]

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Toronto Service Area Office 5700 Yonge Street, 5th Floor Toronto ON M2M 4K5 Telephone: 1-866-311-8002 TorontoSAO.moh@ontario.ca

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:



Ministry of Long-Term Care Long-Term Care Operations Division Long-Term Care Inspections Branch Toronto Service Area Office 5700 Yonge Street, 5th Floor Toronto ON M2M 4K5 Telephone: 1-866-311-8002 TorontoSAO.moh@ontario.ca

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: <u>MLTC.AppealsCoordinator@ontario.ca</u>

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 <u>www.hsarb.on.ca</u>.