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

Toronto District
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 15, 2023

Inspection Number: 2023-1369-0004

Inspection Type:
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Mississauga, Mississauga

Lead Inspector	**Inspector Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.03.27 15:22:20 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 23-24, 27-28, March 1-3, and 6-7, 2023

The following intake(s) were inspected in the Critical Incident System Inspection:

- Intake: #00002405 - [CI: 2884-000009-22] related to falls
- Intake: #00003229 - [CI: 2884-000012-22] related to injury of unknown cause.
- Intake: #00012975 - [CI: 2884-000014-22] related to alleged physical abuse from unknown staff member towards the resident.

The following intake(s) were completed in the Critical Incident System Inspection:

- Intake: #00002344 - [CI: 2884-000005-21] related to injury of unknown cause
- Intake: #00003427 - [CI: 2884-000007-21] related to falls.
- Intake: #00003389 - [CI: 2884-000006-21] related to falls
- Intake: #00003707 - [CI: 2884-000010-21] related to falls
- Intake: #00004633 - [CI: 2884-000008-21] related to falls
- Intake: #00004661 - [CI: 2884-000012-21] related to falls

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed, and the plan of care was revised when the resident's care needs changed.

Rationale and Summary
A resident was assessed by the Physiotherapist (PT) and recommended to use specified level of assistance for transfers. The resident's care plan was not updated to reflect this change.

Assistant Director of Care (ADOC) and Director of Care (DOC) stated that the nursing team was responsible for updating the care plan to reflect the recommended interventions.

The intervention to use specific level of assistance for transfers was updated in the care plan on February 27, 2023.

Failure to ensure that a resident's care plan is up to date may result in an increased risk for injury and an incorrect level of care provided in response to the resident's care needs.

Sources: Resident's care plan, progress notes, PT progress notes, interviews with ADOC, and DOC.

Date Remedy Implemented: February 27, 2023

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NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to implement measures in accordance with the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard).

Specifically, 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary
During an observation, it was noted that the Alcohol Based Hand Rub (ABHR) bottle in the resident home area dining room was expired.

DOC acknowledged that the ABHR was expired and immediately removed the bottle when brought to their attention by the inspector. They indicated that expired ABHR could have decreased effectiveness against pathogens and infection control.

Sources: Observations, and interview with DOC and Infection Prevention and Control (IPAC) Lead.

Date Remedy Implemented: February 23, 2023,

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
A Critical Incident System (CIS) reported that a resident was injured as a result of staff failure to follow their care plan.

The resident required one to two person assistance for personal hygiene and dressing related to responsive behaviours.

The home's investigation notes identified that the resident had sustained an injury when the resident was provided personal care by one staff member.

A Personal Support Worker (PSW) stated that they were providing care to the resident by themselves when the resident became responsive. PSW was aware of the resident's care plan and acknowledged that a second staff was not present when they had initiated the resident's care.

DOC acknowledged that the resident required two-person assistance for personal hygiene and dressing and the resident's care plan was not followed as required.

There was risk and harm to the resident when the care plan was not followed.

Sources: CIS report, resident's clinical records and progress notes, interview with PSW, DOC, and other staff.

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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that for a resident who exhibited responsive behaviours, strategies were developed and implemented to respond to their responsive behaviours.

Rationale and Summary
A CIS report was submitted to the Director related to an incident of alleged abuse.

The home's policy on "Responsive Behaviours" dated January 2022 indicated for all new or escalated behaviours, the home will implement and evaluate strategies and interventions to prevent, minimize and address those behaviours.

The resident's progress notes revealed that they had exhibited responsive behaviours prior to an incident that caused an injury to them.

The resident's care plan indicated interventions were not initiated to manage specified responsive behaviours exhibited prior to the incident that caused an injury to the resident.

Behavioural Support Ontario (BSO) Lead acknowledged that strategies should be identified in the resident's care plan to manage responsive behaviours.

DOC acknowledged that the resident had exhibited responsive behaviours as documented in the progress notes on multiple occasions with no interventions addressing those behaviours until the incident that caused an injury to the resident.

Failure to develop and implement strategies for the resident's responsive behaviours resulted in staff being unaware of what actions to take to prevent or manage the behaviours.

Sources: CIS report, resident's clinical records and progress notes, interview with BSO lead, DOC and other staff.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (a)

The licensee has failed to ensure that that the COVID-19 screening requirements set out in the COVID-19 Guidance Document for Long-Term Care Homes was complied with.

Rationale and summary
In accordance with the measures outlined in the MLTC COVID-19 Guidance Document for LTCHs in Ontario, residents were to be assessed at least once daily for signs and symptoms of COVID-19 including temperature checks.

A Resident's Acute Respiratory Illness-COVID-19 Screen assessments were not completed for 33 days out of 53 days between the period of January 1, 2023, to February 22, 2023.

IPAC Lead and DOC acknowledged that screening assessments were required to be completed daily by staff, and assessments were not completed consistently for the resident.

There was moderate risk to the resident as this would have affected the ability to identify a change in the resident's status related to COVID-19.

Sources: Review of Minister's Directive: COVID-19 response measures for long-term care homes, dated August 30, 2022, MLTC COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2023, COVID-19 Guidance: LTCHs, retirement homes, and other congregate Living settings for Public Health Units dated January 18, 2023, and resident 's clinical records; and interviews with IPAC Lead and DOC.

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WRITTEN NOTIFICATION: REPORTING CRITICAL INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (4) (b)

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident, resulting in a significant change in the resident's health condition, no later than three business days after the occurrence of the incident.

Rationale and Summary
A Resident had a fall and was transferred to hospital for further assessment and treatment. The resident's Substitute Decision Maker (SDM) informed the home of the resident's injuries one day after the incident. The resident returned to the home with a significant change in their mobility and care needs.

The incident was not reported to the Director until six days after the home was informed of the resident's significant injuries.

DOC acknowledged that the incident had caused an injury to a resident resulting in a significant change in their health condition should have been reported to the Director within the three business days.

There was no harm or risk of harm to the resident as a result of the late reporting.

Sources: Resident's progress notes, CIS report, interview and with DOC.

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