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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 3, 2024	
Inspection Number: 2024-1369-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Mississauga, Mississauga	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11-13, 16-20, 2024.
The inspection occurred offsite on the following date(s): September 24, 26-27, 2024.

The following intake(s) were inspected:
• Intake: #00115728 - Critical Incident related to Improper/Incompetent treatment of a resident.
• Intake: #00117839 - Critical Incident related to injury of unknown cause for a resident.
• Intake: #00119503 - Critical Incident related to a resident fall.
• Intake: #00122138 - Complainant related to concerns regarding the care of a resident.

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The following intake was completed in this inspection:
• Intake: #00122069 - Critical Incident related to a resident fall.

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A) The licensee has failed to ensure that allegations of improper care that resulted in harm or risk of harm to a resident were immediately reported to the Director.

Rationale and Summary:
A resident's substitute decision maker (SDM) complained of alleged improper care that resulted in harm or risk of harm to the resident. The home's complaint investigation form identified the complaint as alleged improper care however, it was not immediately reported to the Director.

Ten days earlier, the home submitted a report to the Director regarding a prior verbal complaint from the SDM where improper care was also alleged. The details of second complaint and subsequent investigation by the home were not added to the first report to the Director or submitted to the Director in a separate report.

The Director of Care (DOC) acknowledged that the information from the second complaint, was not added to the first report to the Director, nor submitted separately in another separate report.

Failure to immediately notify the Director of alleged improper care of a resident, that resulted in harm or risk of harm had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: Critical Incident report, home's investigation notes; interviews with the Administrator and DOC.

B) The licensee failed to immediately report to the Director when there were reasonable grounds to suspect that there was improper or incompetent treatment or care of a resident that resulted in harm to the resident.

Rationale and Summary:
A Personal Support Worker (PSW) provided improper care to a resident, resulting in an injury to the resident.

The Registered Practical Nurse (RPN), who was working at the time of the incident, stated the incident would be consistent with improper care of a resident that resulted in harm to the resident. The home's policy directed staff to immediately report to the Director when any person had reasonable grounds to suspect there was improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The incident was not immediately reported to the Director, however, was reported at a later date and under a different category.

Sources: interview with a RPN; clinical health record for a resident, including progress notes, assessments, and plan of care; the home's investigation notes; the home's policy, Jurisdictional Reporting Requirements; and Critical Incident report.

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A) The licensee failed to ensure that any actions taken with respect to a resident, under the fall prevention and management program, including assessments, reassessments, interventions, and the resident's responses to interventions were documented.

Rationale and Summary:
The home's falls prevention and management policy required staff to complete a post fall assessment, which included a post fall huddle, and to document on the assessment form in the Point Click Care (PCC) computer system. Two post fall assessments were initiated after the resident fell however, several sections of the assessments were incomplete, and the post fall assessment did not include documentation of a post fall huddle.

The Registered Practical Nurse (RPN) confirmed the post fall assessment was completed, including the post fall huddle, however, not all sections were documented. The Director of Care (DOC) confirmed the post fall assessment and post fall huddle documentation was incomplete.

Sources: interview with an RPN, DOC; clinical record for a resident, including assessments; Falls Prevention and Management Program policy.

B) The licensee has failed to ensure that any actions taken with respect to a resident, under the pain management program, including interventions and the resident's responses to interventions were documented.

Rationale and Summary:
A resident expressed significant ongoing pain over a three-day period, resulting from an injury.

The resident's routine pain medication was increased and as needed (prn) pain medication was ordered. Documentation reflected the resident identified significant pain on several pain assessments during that time period. No prn pain medication was recorded as offered or provided to the resident over the three identified days.

Three Registered Practical Nurses (RPN) stated that additional pain medication was offered to the resident, however, the resident routinely refused. The staff acknowledged that documentation did not reflect any refusal of the as needed pain medication during the three days identified.

When staff did not document additional pain medication offered to and/or refused by the resident, it was unclear if the resident's pain management plan of care was followed and if alternative strategies may have been more effective.

Sources: the clinical health record for a resident, including progress notes, assessments, and electronic Medication Administration Record (eMAR); and interview with RPNs.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff safely turned and repositioned a resident, resulting in injury to the resident.

Rationale and Summary:
The plan of care for a resident identified that two staff were required at all times when turning and repositioning the resident.

The home's notes identified that a Personal Support Worker (PSW) turned and repositioned the resident without the assistance of another staff member resulting in injury to the resident.

The Registered Practical Nurse (RPN), who was working at the time of the injury, confirmed that the PSW did not follow the resident's plan of care for turning and repositioning the resident. The RPN stated the resident was not safe to care for independently with one staff.

When staff did not safely turn and reposition the resident, it resulted in injury to the resident.

Sources: interview with an RPN; clinical health record for a resident, including progress notes, assessments, and plan of care; the home's investigation notes; Critical Incident report.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure that a documented record was kept in the home that included, every date on which any response was provided to the complainant and a description of the response, related to a verbal complaint from a resident's

substitute decision maker (SDM).

Rationale and Summary:
A resident's SDM complained to the home's administrator. The administrator informed the SDM that their complaint would be immediately investigated, and they would schedule a meeting to provide the results of the investigation and action plan to ensure the resident would be receiving the appropriate care.

A review of the home's complaint investigation form and investigation notes indicated that when their investigation concluded they attempted to contact the SDM. Unable to connect with the SDM, a voice message was left to schedule a face-to-face meeting. The investigation notes documented that they were awaiting a response from the SDM.

The DOC stated that a scheduled meeting did not occur, however, the SDM was informed of the results of the investigation in person at the LTC home. The DOC acknowledged that the documented record of the complaint did not contain the date when the response was provided to the SDM, and description of the response.

Failure to document the date and description of the response to the SDM may have resulted in a misunderstanding of what was communicated to the SDM and when.

Sources: Critical Incident report, home's investigation notes; interviews with the Administrator and DOC.

WRITTEN NOTIFICATION: Records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary:
A Registered Practical Nurse (RPN) completed a head-to-toe skin assessment for a resident and documented about an area on the resident's skin. In the head-to-toe assessment form, the RPN also indicated that referrals would be forwarded to the registered dietitian (RD) and wound care champion, along with weekly wound assessments and/or weekly impaired skin integrity assessments.

The RPN explained to the Inspector that the area was further assessed and did not require further follow up. The RPN acknowledged that they did not document their findings, along with not sending referrals to the RD and wound care champion.

The administrator stated that the RPN had assessed the resident and determined the nature of the area. They had expected the RPN would document the result of their assessment in the resident's written record.

Failure to keep resident's written record up to date regarding altered skin integrity may have resulted in a potential serious skin issue being unidentified.

Sources: resident clinical records; interviews with the Administrator and other staff.