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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 14, 2022	2022_988522_0003	018184-21, 018322-21, 019067-21, 019290-21, 002041-22	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 Southwood Lakes
1255 North Talbot Road Windsor ON N9G 3A4

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

JULIE LAMPMAN (522), LOMA PUCKERIN (705241)

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): February 22, 23, 24, 25, 28, and March 1, 2, and 3, 2022.

The following Critical Incident System (CIS) intakes were inspected:

CIS #2842-000007-22/Log #002041-22 related to falls prevention;
CIS #2842-000059-21/Log #019290-21 related to falls prevention;
CIS #2842-000058-21/Log #018322-21 related to an injury of unknown cause; and
CIS #2842-000057-21/Log #018184-21 related to responsive behaviours.

Log #019067-21 follow-up to Compliance Order #001 from inspection #2021_747725_0039 related to the home's staffing contingency plan was also inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Coordinator, the Resident Assessment Instrument Coordinator, the Nurse Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Behavioural Supports Ontario Personal Support Worker, a Housekeeper and residents.

The inspector(s) also observed infection prevention and control practices in the home, resident care, staff to resident interactions, reviewed resident clinical records, staff training records, the home's staffing contingency plan, and policies and procedures relevant to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **0 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (3)	CO #001	2021_747725_0039	522

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #007's plan of care was based on an assessment of resident #007 and the needs and preferences of resident #007.

On a specific date, resident #007 was observed in their wheelchair, placed in a certain position.

Review of resident #007's plan of care noted resident #007 used a wheelchair. There was no documentation on how resident #007 was to be positioned in the wheelchair.

Personal Support Worker (PSW) #119 stated resident #007 would request to be positioned in their wheelchair for comfort and then ask to be repositioned. PSW #119 stated this was not in resident #007's plan of care.

Registered Practical Nurse (RPN) #126 stated specific positioning of a resident in a wheelchair was not included in a resident's plan of care.

Resident Assessment Instrument Coordinator (RAI-C) #115 stated that specific positioning of a resident in a wheelchair should be included in a resident's care plan.

Sources:
Observations of resident #007, review of resident #007's clinical record and interviews with PSW #119, RPN #126 and RAI-C #115. [s. 6. (2)]

2. A) The licensee has failed to ensure that resident #002 was reassessed and their plan of care reviewed and revised when resident #002 required the use of a wheelchair.

On numerous occasions resident #002 was observed seated in a wheelchair.

Review of resident #002's care plan noted resident #002 walked independently without the use of aids. The care plan noted resident #002 was weak at times and required the use of a wheelchair for portering.

Registered Practical Nurse (RPN) #114 stated resident #002 required the use of a wheelchair at all times.

RPN #114 reviewed resident #002's care plan with Inspector #522 and acknowledged resident #002's care plan had not been updated when the resident no longer ambulated independently and required the use of a wheelchair.

Sources:
Observations of resident #002, review of resident #002's clinical record and interviews with RPN #114, RPN #126 and RAI-C #115.

B) The licensee has failed to ensure that resident #008 was reassessed and their plan of care reviewed and revised when resident #008 required the use of a wheelchair.

On several occasions resident #008 was observed seated in a wheelchair.

Review of resident #008's care plan noted resident #008 walked independently most of the time with limited assistance. The only mention of the use of a wheelchair was that a specific device was to be applied to their wheelchair.

Personal Support Worker (PSW) #119 stated resident #008 had been in a wheelchair for several months and no longer walked.

Registered Practical Nurse (RPN) #126 reviewed resident #008's care plan with Inspector #522 and acknowledged the care plan had not been updated when resident #008 no longer ambulated independently and required the use of a wheelchair.

RAI-C #115 stated the RPN should update a resident's care plan when the resident was

no longer ambulatory and required the use of a wheelchair.

Sources:
Observations of resident #008, review of resident #008's clinical record and interviews with PSW #119, RPN #126 and RAI-C #115.

C) The licensee has failed to ensure that resident #003 was reassessed and their plan of care reviewed when resident #003's care needs changed.

Resident #003 had sustained an injury.

Review of resident #003's progress notes noted there was no documented assessment of resident #003 when they had returned to the home after their injury that required a specific treatment.

Registered Practical Nurse (RPN) #109 reviewed resident #003's clinical record with Inspector #522 and acknowledged there was no documented assessment or monitoring of resident #003's injury and specific treatment.

D) The licensee has failed to ensure that resident #005 was reassessed and their plan of care reviewed and revised when resident #005's care needs changed.

Resident #005 had sustained an injury.

Review of resident #005's progress notes noted there was no documented assessment of resident #005 when they had returned to the home after their injury that required a specific treatment.

Registered Practical Nurse (RPN) #114 stated that each shift staff should document regarding a resident's injury and treatment. RPN #114 reviewed resident #005's progress notes with Inspector #522 and confirmed there was no documented assessment or monitoring of resident #005's injury and specific treatment.

E) The licensee has failed to ensure that resident #006 was reassessed and their plan of care reviewed and revised when resident #006's care needs changed.

Review of resident #006's progress notes indicated resident #006 had sustained an injury.

Review of resident #006's progress notes noted there was no documented assessment of resident #006 when they had returned to the home after their injury that required a specific treatment.

Registered Practical Nurse (RPN) #114 stated that each shift staff should document regarding a resident's injury and treatment. RPN #114 reviewed resident #006's progress notes with Inspector #522 and confirmed there was no documented assessment or monitoring of resident #006's injury and specific treatment.

Registered Nurse (RN) #112 stated Personal Support Workers would monitor a resident and report concerns to registered staff who would document concerns in a progress note.

RN #112 stated staff would not do an assessment or monitor the resident with a specific treatment unless there was a doctor's order.

The Nurse Practitioner (NP) stated when a resident had a specific treatment applied, they would not write an order to assess the resident and treatment as that was part of regular nursing practice to complete an assessment each shift if a resident had a specific treatment.

The NP stated staff should have monitored the residents who had specific treatments in place.

The Director of Care (DOC) stated the home did not have a policy regarding assessment and care of a resident with a specific treatment in place.

Residents #003, #005 and #006 were not assessed and their plans of care not revised after they returned to the home with a specific treatment in place.

This caused actual risk to the residents as they were not assessed and monitored for potential complications of their injury and potential complications of the specific treatment.

Sources:
Review of resident #003, #005 and #006's clinical records and American Academy of Family Physicians Volume 79, Number 1, dated January 1, 2009, and interviews with

RPN #109, RPN #114, RN #112, the NP, the DOC and other staff. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Service Device (PASD) to assist residents #002 and #008 with a routine activity of living was included in each resident's plan of care.

A) On numerous occasions resident #002 was observed with a PASD in place.

Review of resident #002's clinical record noted there was no documentation related to the use of the PASD.

Personal Support Worker (PSW) #110 stated they used the PASD for resident #002 for comfort. PSW #110 acknowledged this was not in resident #002's plan of care.

B) Resident #008 was observed with a PASD in place.

Review of resident #008's clinical records noted there was no documentation related to the use of the PASD.

Personal Support Worker (PSW) #119 stated they used the PASD for resident #008 for comfort. PSW #119 stated they did not think the use of the PASD was in resident #008's plan of care.

The Director of Care (DOC) and Resident Assessment Instrument Coordinator (RAI-C) #115 acknowledged that staff were applying a PASD and it should be included in a resident's plan of care.

Residents #002 and #008 had a PASD applied. This put resident #002 and #008 at actual risk as the residents had not been assessed for the use of the PASD and the use of PASD was not included in their plan of care.

Sources:
Observations of resident #002 and #008, review of resident #002 and #008's clinical record, Extendicare's "Personal Assistance Service Devices (PASDs)" policy RC-22-01-05, dated December 2020, and interviews with PSW #110, PSW #119, RPN #126, RAI-C #115, the DOC and other staff. [s. 33. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the "Skin and Wound Program: Prevention of Skin Breakdown" policy was complied with.

O. Reg. 79/10 s. 48 (1) 2 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcer, and provide effective skin and wound care interventions."

Review of Extendicare's "Skin and Wound Program: Prevention of Skin Breakdown" policy RC-23-01-01, last updated December 2020, noted a head to toe skin assessment was to be completed for all residents upon any return from hospital (admission or emergency room visit), quarterly and as clinically indicated.

A) A review of resident #003's clinical records noted that resident #003 had returned to the home after having a specific treatment removed.

Further review noted that no skin assessments were completed for resident #003 after the specific treatment was removed to check resident #003's skin integrity and for any

pressure areas.

Personal Support Worker (PSW) #118 stated resident #003's skin was dry and crusty after the specific treatment had been removed.

Registered Practical Nurse (RPN) #109 stated when resident #003 returned to the home after having a specific treatment removed, they should have completed a skin assessment on the resident but forgot.

B) A review of resident #005's clinical records noted that resident #005 had a specific treatment removed.

Further review noted that no skin assessments were completed for resident #005 after the specific treatment was removed to check resident #005's skin integrity and for any pressure areas.

Registered Practical Nurse (RPN) #126 reviewed resident #005's clinical records with Inspector #522 and confirmed a skin assessment had not been completed when resident #005 had the specific treatment removed. RPN #126 stated resident #005 should have had a skin assessment completed when the specific treatment was removed.

There was actual risk to residents #003 and #005 as they had a specific treatment removed after several months and they had not been assessed for altered skin integrity or pressure areas, as clinically indicated.

Sources:
Review of resident #003 and #005's clinical record, Extendicare's "Skin and Wound Program: Prevention of Skin Breakdown" policy RC-23-01-01 last updated December 2020, and interviews with PSW #118, RPN #109, RPN #126, RN #112, DOC and other staff. [s. 8. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC).

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including proper use of Personal Protective Equipment (PPE) and staff and resident Hand Hygiene.

Review of Extendicare's "Hand Hygiene" policy IC-02_01-08, last reviewed October 2021, noted staff were to practice hand hygiene when they donned and doffed personal protective equipment (PPE).

Personal Support Worker (PSW) #104 was observed bringing a tray to a resident room which had Additional Precautions signage posted.

Prior to entering the resident’s room, PSW #104 doffed their medical mask and face shield and then donned a gown, N95 mask, face shield and gloves and did not perform hand hygiene.

PSW #104 stated the resident was on Additional Precautions. PSW #104 stated they had sanitized their hands prior to getting the resident’s tray and did not think they needed to sanitize before they doffed their mask and face shield. PSW #104 acknowledged they should have sanitized their hands when they doffed and donned their PPE.

There was actual risk to residents as PSW #104 did not perform hand hygiene when donning and doffing PPE when the home was in a COVID-19 outbreak.

Sources:
Observations of IPAC practices in the home, review of Extendicare's "Hand Hygiene" policy IC-02_01-08, last reviewed October 2021, and interviews with PSW #104 and the Clinical Coordinator. [s. 229. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 and #006's clinical records were kept up to date.

A) Review of resident #005's electronic progress notes in point click care noted that resident #005 had a specific treatment applied.

Further review noted no documentation that the resident had the specific treatment removed.

Registered Practical Nurse (RPN) #126 stated if a resident went for an appointment staff would chart when the resident left and returned to the home and what happened on the appointment.

RPN #126 reviewed resident #005's progress notes with Inspector #522 and acknowledged there was no documentation that resident #005 had left the home and had the specific treatment removed.

B) Review of resident #006's electronic progress notes in point click care noted that resident #006 left the home for a medical assessment.

There was no documentation that resident #006 returned to the home and the resident's status after the medical assessment.

It was not until the following day, that there was documentation that resident #006 had a specific treatment in place after the medical assessment.

Registered Practical Nurse (RPN) #114 stated registered staff should document when a resident left the home and returned. RPN #114 reviewed resident #006's clinical record with Inspector #522 and acknowledged staff did not document when resident #006 returned to the home and resident #006's status upon their return to the home.

RPN #114 stated staff should have documented when #006 returned to the home after the medical assessment.

Sources:
Review of resident #005 and #006's clinical record and interviews with RPN #114, RPN #126, RAI- Coordinator #115 and the DOC. [s. 231. (b)]

Issued on this 4th day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(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 soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522), LOMA PUCKERIN (705241)
Inspection No. / No de l'inspection :	2022_988522_0003
Log No. / No de registre :	018184-21, 018322-21, 019067-21, 019290-21, 002041-22
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 14, 2022
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Southwood Lakes 1255 North Talbot Road, Windsor, ON, N9G-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matthew Summerfield

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c.8 s. 6 (10) (b).

Specifically,
A) Resident #002 and #008 will have their plan of care revised to include the use of a wheelchair, as required.
B) Residents who return to the home with a specific injury will be reassessed and have their plan of care reviewed and revised.
C) The home must develop a policy and procedure regarding the care and assessment of residents who have a specific injury.
D) Registered staff must receive training on the new policy and procedure.
C) The training must be documented, including the date and staff names who attended the training.

Grounds / Motifs :

1. A) The licensee has failed to ensure that resident #002 was reassessed and their plan of care reviewed and revised when resident #002 required the use of a wheelchair.

On numerous occasions resident #002 was observed seated in a wheelchair.

Review of resident #002's care plan noted resident #002 walked independently without the use of aids. The care plan noted resident #002 was weak at times

and required the use of a wheelchair for portering.

Registered Practical Nurse (RPN) #114 stated resident #002 required the use of a wheelchair at all times.

RPN #114 reviewed resident #002's care plan with Inspector #522 and acknowledged resident #002's care plan had not been updated when the resident no longer ambulated independently and required the use of a wheelchair.

Sources:
Observations of resident #002, review of resident #002's clinical record and interviews with RPN #114, RPN #126 and RAI-C #115.

B) The licensee has failed to ensure that resident #008 was reassessed and their plan of care reviewed and revised when resident #008 required the use of a wheelchair.

On several occasions resident #008 was observed seated in a wheelchair.

Review of resident #008's care plan noted resident #008 walked independently most of the time with limited assistance. The only mention of the use of a wheelchair was that a specific device was to be applied to their wheelchair.

Personal Support Worker (PSW) #119 stated resident #008 had been in a wheelchair for several months and no longer walked.

Registered Practical Nurse (RPN) #126 reviewed resident #008's care plan with Inspector #522 and acknowledged the care plan had not been updated when resident #008 no longer ambulated independently and required the use of a wheelchair.

RAI-C #115 stated the RPN should update a resident's care plan when the resident was no longer ambulatory and required the use of a wheelchair.

Sources:
Observations of resident #008, review of resident #008's clinical record and

interviews with PSW #119, RPN #126 and RAI-C #115.

C) The licensee has failed to ensure that resident #003 was reassessed and their plan of care reviewed when resident #003's care needs changed.

Resident #003 had sustained an injury.

Review of resident #003's progress notes noted there was no documented assessment of resident #003 when they had returned to the home after their injury that required a specific treatment.

Registered Practical Nurse (RPN) #109 reviewed resident #003's clinical record with Inspector #522 and acknowledged there was no documented assessment or monitoring of resident #003's injury and specific treatment.

D) The licensee has failed to ensure that resident #005 was reassessed and their plan of care reviewed and revised when resident #005's care needs changed.

Resident #005 had sustained an injury.

Review of resident #005's progress notes noted there was no documented assessment of resident #005 when they had returned to the home after their injury that required a specific treatment.

Registered Practical Nurse (RPN) #114 stated that each shift staff should document regarding a resident's injury and treatment. RPN #114 reviewed resident #005's progress notes with Inspector #522 and confirmed there was no documented assessment or monitoring of resident #005's injury and specific treatment.

E) The licensee has failed to ensure that resident #006 was reassessed and their plan of care reviewed and revised when resident #006's care needs changed.

Review of resident #006's progress notes indicated resident #006 had sustained an injury.

Review of resident #006's progress notes noted there was no documented assessment of resident #006 when they had returned to the home after their injury that required a specific treatment.

Registered Practical Nurse (RPN) #114 stated that each shift staff should document regarding a resident's injury and treatment. RPN #114 reviewed resident #006's progress notes with Inspector #522 and confirmed there was no documented assessment or monitoring of resident #006's injury and specific treatment.

Registered Nurse (RN) #112 stated Personal Support Workers would monitor a resident and report concerns to registered staff who would document concerns in a progress note.

RN #112 stated staff would not do an assessment or monitor the resident with a specific treatment unless there was a doctor's order.

The Nurse Practitioner (NP) stated when a resident had a specific treatment applied, they would not write an order to assess the resident and treatment as that was part of regular nursing practice to complete an assessment each shift if a resident had a specific treatment.

The NP stated staff should have monitored the residents who had specific treatments in place.

The Director of Care (DOC) stated the home did not have a policy regarding assessment and care of a resident with a specific treatment in place.

Residents #003, #005 and #006 were not assessed and their plans of care not revised after they returned to the home with a specific treatment in place.

This caused actual risk to the residents as they were not assessed and monitored for potential complications of their injury and potential complications of the specific treatment.

Sources:

Review of resident #003, #005 and #006's clinical records and American Academy of Family Physicians Volume 79, Number 1, dated January 1, 2009, and interviews with RPN #109, RPN #114, RN #112, the NP, the DOC and other staff.

An order was made by taking the following factors into account:

Severity: Residents #003, #005 and #006 were not assessed and their plan of care not revised after they returned to the home after an injury with a specific treatment in place.

This caused actual risk to the residents as they were not assessed and monitored for potential complications of their injury and potential complications after their treatment was applied.

Scope: The scope of this non-compliance was widespread as resident #002 and #008's plan of care was not reviewed and revised when the residents were no longer ambulatory and residents #003, #005 and #006 were not reassessed and their plans of care were not reviewed and revised after the residents sustained an injury and had a specific treatment applied.

Compliance History: The home had previous noncompliance to a different subsection of LTCHA 2007, c.8 s. 6. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 13, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 33. (3).

Specifically,

A) Resident #002 and #008 are assessed for the use of a specific Personal Assistance Service Device (PASD);
B) Use of a specific PASD is included in the plan of care for resident #002, #008, and any other residents who use a specific PASD.
C) Registered Staff and Personal Support Workers on Devonshire home area receive retraining on the home's minimizing of restraints policy, including the use of PASDs.
D) Training must be documented, including the name of the staff members and the date the training occurred.

Grounds / Motifs :

1. The licensee has failed to ensure that the use of a Personal Assistance Service Device (PASD) to assist residents #002 and #008 with a routine activity of living was included in each resident's plan of care.

A) On numerous occasions resident #002 was observed with a PASD in place.

Review of resident #002's clinical record noted there was no documentation related to the use of the PASD.

Personal Support Worker (PSW) #110 stated they used the PASD for resident #002 for comfort. PSW #110 acknowledged this was not in resident #002's plan

of care.

B) Resident #008 was observed with a PASD in place.

Review of resident #008's clinical records noted there was no documentation related to the use of the PASD.

Personal Support Worker (PSW) #119 stated they used the PASD for resident #008 for comfort. PSW #119 stated they did not think the use of the PASD was in resident #008's plan of care.

The Director of Care (DOC) and Resident Assessment Instrument Coordinator (RAI-C) #115 acknowledged that staff were applying a PASD and it should be included in a resident's plan of care.

Residents #002 and #008 had a PASD applied. This put resident #002 and #008 at actual risk as the residents had not been assessed for the use of the PASD and the use of PASD was not included in their plan of care.

Sources:
Observations of resident #002 and #008, review of resident #002 and #008's clinical record, Extendicare's "Personal Assistance Service Devices (PASDs)" policy RC-22-01-05, dated December 2020, and interviews with PSW #110, PSW #119, RPN #126, RAI-C #115, the DOC and other staff.

An order was made by taking the following factors into account:

Severity: Residents #002 and #008 were oberved with a PASD in place. This put resident #002 and #008 at actual risk as the residents had not been assessed for the use of the PASD and the use of the PASD was not included in their plan of care.

Scope: The scope of this non-compliance was a pattern as two out of three residents observed did not have the use of a PASD included in their plan of care.

Compliance History: The home had no previous noncompliance to this section of

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Ministère des Soins de longue durée

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Ordre(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

LTCHA 2007. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 10, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(s) de l'inspecteur

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Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8 (1) (b).

Specifically,

A) Staff comply with the home's skin and wound policies.
B) Residents who have a specific treatment removed have a skin assessment completed.
C) Audits are to be completed on all residents who have a specific treatment removed to ensure a skin assessment is completed for altered skin integrity and pressure areas.
D) Audits must be completed for six months or until inspectors determine compliance has been achieved.

Grounds / Motifs :

1. The licensee has failed to ensure the "Skin and Wound Program: Prevention of Skin Breakdown" policy was complied with.

O. Reg. 79/10 s. 48 (1) 2 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcer, and provide effective skin and wound care interventions."

Review of Extendicare's "Skin and Wound Program: Prevention of Skin Breakdown" policy RC-23-01-01, last updated December 2020, noted a head to toe skin assessment was to be completed for all residents upon any return from hospital (admission or emergency room visit), quarterly and as clinically indicated.

A) A review of resident #003's clinical records noted that resident #003 had returned to the home after having a specific treatment removed.

Further review noted that no skin assessments were completed for resident #003 after the specific treatment was removed to check resident #003's skin integrity and for any pressure areas.

Personal Support Worker (PSW) #118 stated resident #003's skin was dry and crusty after the specific treatment had been removed.

Registered Practical Nurse (RPN) #109 stated when resident #003 returned to the home after having a specific treatment removed, they should have completed a skin assessment on the resident but forgot.

B) A review of resident #005's clinical records noted that resident #005 had a specific treatment removed.

Further review noted that no skin assessments were completed for resident #005 after the specific treatment was removed to check resident #005's skin integrity and for any pressure areas.

Registered Practical Nurse (RPN) #126 reviewed resident #005's clinical records with Inspector #522 and confirmed a skin assessment had not been completed when resident #005 had the specific treatment removed. RPN #126 stated resident #005 should have had a skin assessment completed when the specific treatment was removed.

There was actual risk to residents #003 and #005 as they had a specific treatment removed after several months and they had not been assessed for altered skin integrity or pressure areas, as clinically indicated.

Sources:
Review of resident #003 and #005's clinical record, Extendicare's "Skin and Wound Program: Prevention of Skin Breakdown" policy RC-23-01-01 last updated December 2020, and interviews with PSW #118, RPN #109, RPN #126, RN #112, DOC and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents #003 and #005 as they had a specific treatment removed and they had not been assessed for altered skin integrity or pressure areas, as clinically indicated.

Scope: The scope of this non-compliance was a pattern as two out of three residents had not had a skin assessment completed.

Compliance History: The home had previous noncompliance within the last 36 months to this subsection of O. Reg. 79/10. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 229 (4).

Specifically;
A) All staff must practice hand hygiene when donning and doffing Personal Protective Equipment (PPE).
B) Personal Support Worker #104 must receive retraining on the home's hand hygiene policy, including demonstrating proper hand hygiene when donning and doffing PPE.
C) Training must be documented, including the date the training occurred.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC).

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including proper use of Personal Protective Equipment (PPE) and staff and resident Hand Hygiene.

Review of Extendicare's "Hand Hygiene" policy IC-02_01-08, last reviewed October 2021, noted staff were to practice hand hygiene when they donned and doffed PPE.

On February 22, 2022, at 1202 hours, on Essex Home Area, PSW #104 was observed bringing a tray to resident room 2217, which had Droplet and Contact Precaution signage posted.

Prior to entering the resident's room, PSW #104 doffed their medical mask and face shield and then donned a gown, N95 mask, face shield and gloves and did not perform hand hygiene.

PSW #104 stated the resident in room 2217 was COVID-19 positive. PSW #104 stated they had sanitized their hands prior to getting the resident's tray and did not think they needed to sanitize before they doffed their mask and face shield. PSW #104 acknowledged they should have sanitized their hands when they doffed and donned their PPE.

There was actual risk to residents as PSW #104 did not perform hand hygiene when donning and doffing PPE when the home was in a COVID-19 outbreak.

Sources:
Observations of IPAC practices in the home, review of Extendicare's "Hand Hygiene" policy IC-02_01-08, last reviewed October 2021, and interviews with PSW #104 and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents as PSW #104 did not perform hand hygiene when donning and doffing PPE when the home was in a COVID-19 outbreak.

Scope: The scope of this non-compliance was isolated.

Compliance History: The home had previous noncompliance within the last 36 months to this subsection of O. Reg. 79/10. (522)

Ontario

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Ministère des Soins de longue durée

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Ordre(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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 11, 2022

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, commercial courier or by fax 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
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale 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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

Service Area Office /
Bureau régional de services : London Service Area Office