Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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

Original Public Report

Report Issue Date: April 13, 2023

Inspection Number: 2023-1064-0002

Inspection Type:
- Complaint
- Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare St. Catharines, St Catherines

Lead Inspector	**Inspector Digital Signature**
Jennifer Allen (706480)	Jennifer L Allen Digitally signed by Jennifer L Allen Date: 2023.04.17 13:42:09 -04'00'

Additional Inspector(s)
Karlee Zwierschke (740732)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 22-24, 27-31, 2023.

The following intakes were inspected in this complaint inspection:
- Intake: #00014914 - Complaint- Concerns relating to plan of care.
- Intake: #00017576 - Complaint - Concerns relating to medication administration, call bells, and universal masking.
- Intake: #00018660 - Complaint - Concerns relating to medication administration related to Diabetes management and fall of a resident that resulted in an injury.

The following intakes were inspected in this Critical Incident (CI) inspection:
- Intake: #00005441 - 2321-000030-22 - UNRESPONSIVE HYPOGLYCEMIC of a resident
- Intake: #00014540 - 2321-000049-22 - Injury of resident, etiology unknown.
- Intake: #00017835 - 2321-000006-23 - Fall of a resident resulting in an injury.

The following intakes were completed in this inspection:

- *Intake #00005437, CI#2321-000035-21, Intake #00008089, CI#2321-000038-22, Intake #00009345, CI#2321-000043-22, Intake #00011580, CI#2321-000045-22, Intake #00016507, CI#2321-000052-22, Intake #00020840, CI#2321-000013-23 and Intake #00018664, CI#2321-000010-23 relating to Fall prevention and management.*

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

- **Resident Care and Support Services**
- **Medication Management**
- **Housekeeping, Laundry and Maintenance Services**
- **Infection Prevention and Control**
- **Safe and Secure Home**
- **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 (2)

The licensee failed to ensure that the care set out in the plan of care was based on the preferences of the resident.

Rationale and Summary
A resident purchases and consumes alcohol. The resident's plan of care did not include the resident's preference to drink alcohol. Staff were aware that the resident chooses to drink alcohol and continue to educate the resident on the risks.

Sources: the resident's clinical record, interview with DOC

Date Remedy Implemented: March 29, 2023
[740732]

WRITTEN NOTIFICATION: Resident's Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee failed to ensure that a resident's right to receive care and services that was consistent with their needs was fully respected and promoted.

Rationale and Summary
A resident was complaining of pain and the doctor ordered a diagnostic test. The test was not completed, and the doctor ordered another test a few days later. At this point the resident experienced swelling to the site of the pain and was unable to weight bear. The doctor ordered a third and different imaging test which showed that the resident now had a medical condition to the affected site. The second diagnostic test order was not processed until several day later, after the DOC directed the registered staff to process the order. The diagnostic test was completed, which showed an injury to the pain site. The resident was then sent to hospital and had surgery to the affected site.

There was an extensive delay before the resident's diagnostic test was completed that showed an injury to the affected site. The resident had ongoing pain during this time and was at risk of complications from an untreated injury.

Sources: the resident's clinical record, interviews with staff and the DOC.
[740732]

WRITTEN NOTIFICATION: Plan of Care

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

The licensee has failed to ensure that a resident had a written plan of care that set out, clear directions to staff who provide direct care to the resident, specifically regarding medication administration.

Rationale and Summary
A resident had a medical diagnosis with unpredictable blood values.

The resident's electronic medication administration records (eMAR) indicated specific medication orders. The resident's family only wanted their specialist to manage the resident's specific medical condition and an order was received from the specialist with specific parameters when administering the medication.

The resident's health record documentation from January 1 – March 29, 2023, indicated the resident's medication was not given numerous time beyond the parameters ordered by the specialist.

The resident's family makes requests for staff to not give the medication when the resident's blood value are in the range of the parameters from the specialist. The homes attending physician was aware of the family's wishes, but no written instructions had been received to provide guidance to the staff.

The DOC acknowledged that the registered staff were confused and expressed concerns regarding the specific medication administration parameters for the resident.

Another medication was identified that included the direction to not give the medication when certain criteria were met. There was no physician order found in the resident's chart that gave this direction in relation to not giving the medication.

An unclear plan of care for medication and management of the medical condition may result in unclear direction to staff, elevated blood values, associated complications and the prescriber not having accurate information when adjusting dosage.

Sources: resident's clinical records, eMARs, interviews staff and with the DOC.
[706480]

WRITTEN NOTIFICATION: Minister's Directives

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applied to the long-term care home, the operational Minister's Directive was complied with.

Rationale and Summary
A) In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, effective April 15, 2020, the licensee was required to ensure that every use of glucagon involving a resident was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the glucagon, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The hypoglycemic event report did not identify that the Medical Director was informed.

Sources: hypoglycemic event report, progress notes, interview with the DOC.
[740732]

Rationale and Summary
B) The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, effective August 30, 2022, requires the licensee to ensure that all staff, students, and volunteers wear a medical mask for the entire duration of their shift indoors and must ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas.

The staff in the reception area were not wearing their masks properly, both staff members were within six feet of one another in the reception area.

Failure of the home to ensure the staff member followed universal masking guidelines increased the risk for infection transmission.

Sources: Observations; Minister's Directive: COVID-19 response measures for long-term care homes, updated August 30, 2022; COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated December 23, 2022; interviews with the DOC and the IPAC lead.
[706480]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the home's falls prevention and management program was followed, specifically where staff were required to complete a post-fall assessment and clinical monitoring record for 72 hours.

In accordance with O.Reg 246/22 s. 11 (1) (b) the licensee is required to ensure the home has in place a falls prevention and management program which includes monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program" reviewed January 2023.

Rationale and Summary
A resident had a fall where they sustained an injury. The homes Falls Prevention Program policy required staff to complete the clinical monitoring record for 72 hours after a fall where the resident sustained an injury. The DOC confirmed that the clinical monitoring record was not completed for the full 72 hours as required by policy.

Not completing the required assessments post-fall may have placed the resident at risk of complications that could have been identified through the required assessments.

Sources: the resident's clinical record, interview with the DOC, Falls Prevention Program Policy (RC-15-01-01).
[740732]

WRITTEN NOTIFICATION: Pain Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee has failed to ensure that the home's pain prevention and management program was

followed, specifically where staff were required to complete a comprehensive pain assessment when a resident had new pain.

In accordance with O.Reg 246/22 s. 11 (1) (b) the licensee is required to ensure the home has in place a pain management program which includes assessment methods of residents, and that it must be complied with.

Specifically, staff did not comply with the policy "Pain Prevention and Management" revised January 2022.

Rationale and Summary
A resident had reported complaints of new pain to a specific area. The home's Pain Prevention and Management policy required staff to complete a comprehensive pain assessment for any new pain. The DOC confirmed that the comprehensive pain assessment was not completed for the new pain as required by policy.

Failure to perform a comprehensive pain assessment as per policy may have put the resident at risk of having unmanaged pain.

Sources: the resident's clinical record, interview with the DOC, Pain Prevention and Management Policy (RC-19-01-01).
[740732]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
-Educate two specified staff members on transferring and positioning techniques including where to find a resident's transfer status
-Document the education, including the content, date, signatures of staff who attended and the staff member who provided the education
-Complete three transferring audits per week on the two specified staff member for one month

-Maintain a record of these audits and document any actions taken for inspector review

Grounds
The licensee failed to ensure that two staff used safe transferring and positioning devices or techniques when assisting resident #002.

Rationale and Summary
A resident's care plan indicated that the resident required a specific lift for transferring and toileting. Two staff members used a different lift to transfer the resident. The resident was left unattended and fell forward resulting in an injury.

By not using the correct lift to transfer the resident and leaving the resident unattended the resident fell and sustained injuries.

Sources: interview with staff and the DOC, the resident's clinical record.
[740732]

This order must be complied with by May 12, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO issued for LTCHA 2007, s. 36, from Inspection # 2021_820130_0010.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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 www.hsarb.on.ca.