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
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Original Public Report

Report Issue Date: May 27, 2024

Inspection Number: 2024-1064-0001

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

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

Lead Inspector	**Inspector Digital Signature**
Cathy Fediash (214)	Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2024.05.27 08:23:09 -04'00'

Additional Inspector(s)
Sydney Withers (740735)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, 2024 and May 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 2024.

The following intake(s) were inspected:

- Intake: #00107723 -CI #2321-000004-24- related to prevention of abuse and neglect.
- Intake: #00108248 -CI #2321-000008-24 - related to resident care and support services.
- Intake: #00108820 -CI #2321-000009-24 - related to resident care and support services.
- Intake: #00109510 -CI #2321-000011-24 - related to prevention of abuse and neglect.

- Intake: #00110331 -CI #2321-000017-24 - related to resident care and support services.
- Intake: #00111212 -CI #2321-000020-24 - related to infection prevention and control.
- Intake: #00113550 -CI #2321-000028-24 - related to food, nutrition, and hydration.

The following intake(s) were completed in this inspection:

- Intake: #00096681 -CI #2321-000054-23 - related to Infection Prevention and Control.
- Intake: #00102726 -CI #2321-000064-23 - related to Infection Prevention and Control.
- Intake: #00107218 -CI #2321-000003-24 - related to Infection Prevention and Control.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to uphold a resident's right to be afforded privacy when a Personal Support Worker (PSW) was caring for their personal needs.

Rationale and Summary
During a tour of the home, a PSW was observed providing care to a resident. The bedroom and washroom doors were open, and the resident was visible from the hallway of the resident home area (RHA). A co-resident was passing by the room at the time of the observation. The PSW acknowledged the resident should have been afforded privacy during care.

Failing to uphold the resident's right to be afforded privacy had the potential for care not being provided in a dignified manner.

Sources: Observation of a resident and an interview with the PSW. [740735]

WRITTEN NOTIFICATION: Plan of Care - Staff and Others to be Kept Aware

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that staff who provided direct care to residents had convenient or immediate access to the plan of care.

Rationale and Summary

The definition of staff as defined in subsection 2 (1) of the Fixing Long-Term Care Act includes persons who work at the home pursuant to a contract or agreement between the licensee and an employment agency.

A) A Resident had a one to one (1:1) staff intervention in place for the past five months for the purpose of behaviour management and provision of direct care. The 1:1 PSWs, who were staffed by an employment agency, did not have a computer login to access the complete plan of care, through Point of Care (POC) and were instead provided access to a 1:1 binder. The binder contained a summary of the resident's behavioural triggers and a daily care documentation form and was not a complete plan of care and did not contain a description of PSW tasks to be completed on each shift. A PSW who provided direct care to the resident as a 1:1 on a specified date, stated that they referred to the 1:1 binder for the resident's care requirements. The Administrator indicated that the process for 1:1 PSWs to access the plan of care was in the 1:1 binder they were provided at the beginning of their shift.

The home's policy titled "Health Care Record" required health care records to be available at the point of care and for health care personnel to at all times, have access to information included in the health record. The policy defined health care record as a primary repository of information including medical and therapeutic treatment and intervention for the health and well-being of the resident during an episode of care and informs care in future episodes.

Sources: The resident's clinical record, 1:1 binder, policy RC-10-01-01 "Health Care

Record" (last reviewed January 2022), interviews with the Resident Care Manager (RCM), Acting Director of Care (ADOC), Administrator and the PSW. [740735]

B) A CIS report was made by the home alleging improper care by a PSW, who was staffed by an employment agency. The long-term care home's (LTCH) investigation records and an interview with the ADOC confirmed the PSW provided resident care independently on a specified shift, while two PSWs who were employed by the home provided care to other residents. The PSW indicated they did not have access to the complete plan of care through POC and instead, referred to care directions posted to the inside of the resident's bedroom closet door. The Administrator stated the PSW had access to the resident's plan of care through the care poster on their closet door. The poster displayed the resident's planned care for two activities of daily living, which was not reflective of their complete plan of care.

The Administrator stated agency PSWs should be set up with a login to access POC through the home's information technology resources, with the assistance of the charge nurse, as laid out in a binder at the nurse's station. The home was unable to demonstrate a formalized process for providing agency PSWs with access to the resident's complete plan of care through POC. The ADOC and Resident Assessment Instrument (RAI) Coordinator acknowledged that at the time, agency PSWs did not receive a login to access POC.

When 1:1 and agency PSWs did not have convenient or immediate access to residents' complete plans of care, this posed a risk that residents were not offered or receiving the care they required.

Sources: A resident's care poster and clinical record, a critical incident report, LTCH investigation records, interviews with Administrator, ADOC, RAI Coordinator and the PSW. [740735]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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.

The licensee failed to ensure that a member of the staff immediately reported to the Director, their suspicion of improper care by a staff to a resident.

Rationale and Summary

A CIS submitted by the home indicated that on a specified date, a support staff member received a complaint from a resident alleging staff had provided improper care to them.

The staff confirmed they had received the allegation and as the resident was unable to recall certain details, they followed up with them the following day. The allegation was not reported to the Administrator until this day.

An interview with the support staff and the Director of Care, confirmed the allegation had been reported to the Director the day after, and not immediately.

Failing to report allegations of improper care to the Director immediately, has the potential to result in a delay in the home commencing an investigation and potentially placing residents at a risk of harm.

Sources: A critical incident report; the home's investigative notes; and interviews with the support staff and the DOC. [214]

WRITTEN NOTIFICATION: General Requirements

NC #004 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.

The licensee failed to ensure that any actions taken with respect to two resident's under the nursing and personal support services program, including interventions and the resident's responses to interventions were documented by PSW staff.

Rationale and Summary
A) A resident had a 1:1 staff intervention in place for several months for behaviour management and to reduce their fall risk. The 1:1 was also considered their primary PSW assignment and provided direct care to the resident. The 1:1 PSWs, who were staffed by an employment agency, did not have a computer login to access the complete plan of care, through POC. Further, they were expected to document in the 1:1 binder and were to report care activities to the floor PSW staff to document on their behalf in POC.

i) The 1:1 binder did not contain a complete plan of care for reference or provide a process for 1:1 PSWs to document provision of all the care required by the resident as per their plan. A PSW, who regularly provided care to the resident and had access to POC, indicated they were unclear who was to document care on the

resident and understood that the 1:1 PSW was responsible for documenting care in the 1:1 binder. Documentation of PSW care tasks required each shift for the resident were reviewed for an identified period and gaps in documentation across all tasks were identified on multiple dates and shifts. When the process for floor PSWs and 1:1 PSWs to document interventions, including the resident's response to interventions was unclear, this contributed to gaps in documentation of actions taken under the nursing and personal support services program.

The home's policy titled "Health Care Record" required all documentation in a resident's health care record to provide an accurate description of the resident's episodes of care and/or contact with health care personnel. When floor PSWs were to document on behalf of the 1:1 PSWs, resident contact with health care personnel was not accurately described, as POC demonstrates the name of the PSW who signed off on the care being provided.

ii) A resident had a nutritional intervention in place in their room. PSWs were responsible for providing the nutritional intervention to the resident as requested and to supplement intake due to increased nutritional needs. The tasks in POC did not include a task for documenting this nutritional intervention. Further, the daily care documentation sheet in the 1:1 binder did not include a task for staff to document when or which nutritional intervention was provided to and consumed by the resident.

Failure to accurately and consistently document provision of nourishments from the nutritional intervention in the residents room, may have resulted in difficulty assessing the resident's nutrient intake and an incomplete record of food intake.

Sources: A resident's clinical record, 1:1 binder contents, policy RC-10-01-01 "Health Care Record" (last reviewed January 2022), interviews with the RCM, DOC, ADOC,

Registered Dietitian (RD) and a PSW. [740735]

B) A CIS report was made by the home alleging improper care of a resident by a PSW. The LTCH investigation records and an interview with the ADOC confirmed the agency PSW was providing resident care on their own on an identified shift, while two PSWs who were employed by the home provided care to other residents. The agency PSW indicated they did not have computer login access to POC, where PSWs document care provided.

The home's policy titled "Health Care Record" required all documentation in a resident's health care record to provide an accurate description of the resident's episodes of care and/or contact with health care personnel. The ADOC acknowledged that that agency PSWs were to tell PSWs employed by the home what care was provided so they could document on their behalf in POC.

When PSWs employed by the home were to document provision of care by agency PSWs, resident contact with health care personnel was not accurately documented.

Sources: A critical incident report, LTCH investigation records, policy RC-10-01-01 "Health Care Record" (last reviewed January 2022), interviews with the ADOC and a PSW. [740735]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 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 used safe positioning techniques when assisting a resident.

Rationale and Summary
A CIS submitted by the home indicated a PSW staff member was independently assisting a resident with two care requirements when the resident sustained a fall from their bed. The CIS indicated the resident required two staff to perform these care requirements. The resident was transferred to hospital and received treatment.

The home's investigative notes, including statements from two PSW staff, one whom witnessed the incident, indicated that a PSW staff had independently provided the care requirements for the resident and during the care, the resident fell from the bed and onto the floor.

The most recent Minimum Data Set (MDS) coding indicated the resident was coded as requiring extensive assistance of two or more staff for the specified care need the staff had provided to the resident.

An applicable assessment indicated the resident's ability to perform a certain task was poor. Their electronic care plan in place at the time of the incident indicated the resident required extensive assistance of two staff for the specified care needs.

Interviews with the DOC and ADOC, indicated that the PSW confirmed they had not been aware of the resident's plan of care needs for the specified care they provided. They confirmed that the PSW staff had not used safe positioning techniques when they assisted the resident.

When positioning techniques are not implemented as assessed, there is a potential for harm to occur to the resident.

Sources: A critical incident report; the home's investigative notes; the resident's MDS coding and assessment, care plan and interviews with the DOC and ADOC. [214]

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm as a result of a resident's responsive behaviour.

Rationale and Summary
A CIS submitted by the home indicated that during the provision of care, a resident demonstrated an identified responsive behaviour toward a PSW staff member.

The home's investigative notes and interviews indicated the resident had been in their room and two PSW staff were present. One of the PSW staff had been bent down in front of the resident to complete a task, when the resident demonstrated a responsive behaviour towards this staff member.

Interviews indicated the resident had at least a year long history of demonstrating this behaviour on persons, items and during meals.

Interviews and a review of the resident's plan of care, including their care plan document indicated no procedures and or interventions including infection prevention and control measures, had been developed so they could be implemented to assist residents and staff who were at risk of harm due to this responsive behaviour.

When procedures and interventions are not developed and implemented to assist residents and staff in response to a resident's responsive behaviour, this has the potential to place these individuals at risk for altercations, harmful interactions, and transmission of disease.

Sources: A critical incident report; the home's investigative notes; a resident's plan of care including care plan and interviews with two PSW staff and the acting ADOC. [214]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes

was implemented.

Rationale and Summary
The IPAC Standard indicated under section 9.1 that additional precautions were to be followed in the IPAC program which included f) the proper use of personal protective equipment (PPE) including the appropriate selection, application, removal and disposal of PPE.

Contact precautions were in place for a resident related to an identified infection which required staff to use specified PPE when providing care to them.

i) A PSW staff was observed providing direct care to the resident wearing gloves and no gown. They indicated that gown and gloves were required and that both items of PPE should have been donned prior to providing care to the resident. The home's contact precaution policy required all care staff to use contact precautions when providing care to a resident with this type of infection.

ii) A PSW exited a resident's room with the resident after providing a care task and did not remove or dispose of their gloves before leaving the room. The PSW was observed to conduct another care task in the hallway while wearing the same gloves. The home's PPE policy required staff to dispose of all PPE before leaving the resident's room and the routine practices policy indicated gloves as a task-specific and single use PPE. The IPAC Manager acknowledged that staff were expected to remove and dispose of their gloves prior to leaving the room and perform hand hygiene prior to completing another task.

There was an increased risk of infectious disease transmission when staff did not practice proper use of PPE during and after provision of care to the resident.

Sources: Observation of a resident's room, review of the resident's clinical record,

IPAC Standard (dated September 2023), policy IC-03-01-08 "Contact Precautions" (last reviewed January 2024), policy IC-03-01-07 "Personal Protective Equipment" (last reviewed January 2024), policy IC-02-01-01 "Routine Practices" (last reviewed January 2024), interviews with the IPAC Manager, a Registered Nurse (RN) and a PSW. [740735]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection were recorded.

Rationale and Summary
A resident demonstrated multiple symptoms of a respiratory infection on an identified date and was placed in isolation with enhanced precautions in place. Symptom documentation was not completed on three shifts, for three consecutive days, including the identified date above while the resident remained symptomatic, with additional precautions in place and had not consented to being tested for the source of their infection. The IPAC Manager acknowledged that staff were expected to complete symptom monitoring and documentation every shift for the duration of the resident's isolation period.

When symptoms of infection were not recorded on every shift, this led to incomplete symptom surveillance and the potential for changes to the resident's clinical presentation being missed.

Sources: A resident's clinical record, interviews with the IPAC Manager and a RN. [740735]

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to immediately inform the Director in as much detail as was possible in the circumstances, of an unexpected or sudden death, followed by completion of the report required under subsection (5).

Rationale and Summary
The LTCH was made aware that a resident passed away. A CIS report was submitted the following day. An RN indicated that they notified the oncoming registered nursing staff about the resident's death and were aware of the Ministry of Long-Term Care (MLTC) reporting requirements; however, did not contact the MLTC After-Hours Line or inform the on-call manager as their shift had concluded. The DOC acknowledged that the resident's death was unexpected and that the Director

was not immediately informed of their death.

Sources: A resident's progress notes, a critical incident report, interviews with the DOC and an RN. [740735]