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

**Ottawa District**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

| |
|---|
| **Report Issue Date:** February 2, 2024 |
| **Inspection Number:** 2024-1207-0001 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **Licensee:** Extendicare (Canada) Inc. |
| **Long Term Care Home and City:** Extendicare West End Villa, Ottawa |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Dee Colborne (000721) | Diana (Dee) Colborne<br>Digitally signed by Diana (Dee) Colborne<br>Date: 2024.02.05 11:24:07 -05'00' |

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4, 5, 8, 9, 10, 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00099514 - Injury to resident with unknown etiology.
- Intake: #00100151 - Complaint in regards to diet/meal planning.
- Intake: #00102039 - Complaint regarding being removed off the Long Term Care home list.
- Intake: #00103317 - Complaint regarding skin and wound care.
- Intake: #00104534 - COVID Outbreak declared.
- Intake: #00105251 - COVID outbreak declared.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Admission, Absences and Discharge

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Authorization for Admission to a home

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

**Non-compliance with: FLTCA, 2021, s. 51 (9)**

Authorization for admission to a home

s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,

(a) the ground or grounds on which the licensee is withholding approval;

(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;

(c) an explanation of how the supporting facts justify the decision to withhold approval; and

(d) contact information for the Director.

The licensee has failed to ensure that the applicant, who had their admission to the home refused/withheld, was provided with written notice setting out a detailed explanation in regards to the following:

(a) the ground or grounds on which the licensee is withholding approval;

(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and
(d) contact information for the Director.

**Rationale and Summary:**
Review of the applicants application for admission did not include a written notice setting out a detailed explanation of the supporting facts for refusal.
Upon interview with the homes Administrator #106, they confirmed that a refusal letter was not completed at the time of the refusal and that the applicant/SDM were not notified of the homes decision for refusal.
Upon interview with the placement coordinator for Home Community Care and Support Services(HCCSS) #113, they confirmed that a refusal letter was not completed at the time of the refusal on a specified date in November 2023.

**Sources:** Review of applicants documentation for admission approval, interviews with Administrator #106 and the Placement Coordinator for (HCCSS) #113.
[000721]

## WRITTEN NOTIFICATION: Skin and Wound Program-Assessments

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the

development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the skin and wound care policy was complied with for resident #002. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a skin and wound program to prevent and identify issues of skin integrity, and it must be complied with.

**Rationale and Summary:**

On a specified date in October 2023, resident #002 was identified as having an injury of unknown cause which required the resident to be assessed in the emergency department. Resident #002 returned the same day diagnosed with a significant injury.
Upon record review with the DOC #112, no head-to-toe assessment was found to be documented on resident #002 on a specified date in October 2023.
Review of the home's Policy RC-23-01-01 in regards to the Skin and Wound program, indicates that a head-to-toe assessment must be completed upon any resident's return from hospital if it is a visit for admission or emergency services.

DOC #101 stated that a head-to-toe assessment must be completed and documented in the home's electronic charting system as part of the skin and wound management program when a resident is out for longer than 24 hours, hospital admission of greater than 24 hours or when they are a new admission. They were not aware that they are to have skin and wound assessment on return from any return from hospital.

Failure to ensure a skin assessment was completed and documented upon resident #002's return from hospital increases the risk for poor continuity of care in ensuring

that the skin integrity status of a resident is effectively communicated.

**Sources:** Policy RC-23-01-01 Head to Toe Assessment. Resident #002's progress notes, resident #002 consult reports and emergency room visit, Interviews with RN #112, DOC #101, and other staff.

[000721]

## WRITTEN NOTIFICATION: Skin and Wound Program-Treatments

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident receives immediate treatment and interventions to promote healing and prevented infections of skin and wound. Specifically, the home missed providing dressing treatments to resident #001 on several occasions over a period of several months.

**Rationale and summary:**
Record review of resident #001 treatment records from the period between October 2023-January 2024 identified several instances where the treatment was not documented as completed. Resident #001 had several documented wounds in total during the time between October 2023-January 2024. During this time there were ten instances that treatments were not signed for as being completed.

Interviews with both the ADOC (Assistant Director of Care) and the wound care champion for the home confirmed that treatments are to be completed and documented on the treatment administration record (TAR).

Failure to ensure treatments are completed as prescribed increases the risk for further impaired skin integrity.

**Sources:** Resident #001 treatment records, interviews with ADOC, Wound Care Champion and other staff.
[000721]

## WRITTEN NOTIFICATION: Skin and Wound Program-repositioning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that resident #001 who was dependent on staff for repositioning, was re-positioned every two hours as per resident #001's written plan of care.

**Rationale and Summary:**
Resident #001's written plan of care identifies that resident#001 is dependent on staff to turn and reposition every two hours and has multiple areas of impaired skin

integrity.

Review of resident #001's documentation for turning and repositioning from July 2023- January 2024 noted that there were 62 instances where the resident was not turned and repositioned.

Interview with PSW #105 confirmed that resident #001 is to be turned and repositioned every two hours and there is a repositioning clock over the residents bed on the wall to follow.
Interview with RPN/Wound care champion confirmed that resident #001 is to be turned and repositioned every two hours.
Interview with DOC confirmed that staff are to sign off/document that they turned and repositioned residents.

Failure to reposition and turn a resident as per the written plan of care, increases the risk for further impaired skin integrity.

**Sources:** Resident #001's repositioning documentation and written plan of care, Interviews with PSW #105, RPN/Wound Care Champion, and DOC.
[000721]

## WRITTEN NOTIFICATION: IPAC- Hand Hygiene

NC #005 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 has failed to implement the Infection Prevention and Control (IPAC) Standard issued by the Director with respect to infection prevention and control measures for hand hygiene.

The home failed to ensure residents were supported to perform hand hygiene prior to receiving a meal, as part of the IPAC program, was followed by staff during meal service in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes September 2023" (IPAC Standard).

Specifically, residents did not receive support from staff in the third floor dining room with hand hygiene prior to a lunch meal as required in the Hand Hygiene Program requirement 10.4 (h) under the IPAC Standard.

**Rationale and Summary:**
On a specified date in January 2024, inspector #000721 observed the lunch time dining service. When the inspector first arrived, there were 12 residents already seated in the dining room. Inspector noted cleaning wipes attached to the walls in different areas of the dining room. There was no hand sanitizer on any of the tables as previously stated by the IPAC lead. Inspector observed residents entering the dining room who were not offered or assisted to perform hand hygiene. One resident who was in a wheelchair entered and was placed at a table, and not offered or encouraged to perform hand hygiene prior to being served their meal. Another resident entered the dining room independently via walker and sat at a table and was not offered hand hygiene prior to being served their meal. Resident #004 entered dining room and was not offered or asked about hand hygiene prior to being served their meal. Another resident entered dining room in their wheelchair and they were using their hands to push the wheels and was not offered hand hygiene when they entered to the dining room prior to being served their meal.

Interview with RPN #108 confirmed that staff should be offering and assisting residents with hand hygiene prior to and after meals.
Interview with IPAC lead #102 confirmed that staff are to assist residents with hand hygiene prior to meals and that the third-floor dining tables are to have hand hygiene dispensers.

Failure to ensure residents are assisted with Hand hygiene prior to meals increases the risk for disease transmission.

**Sources:** Inspector #000721 observations, interview with IPAC lead #102, RPN #108.
[000721]

## COMPLIANCE ORDER CO #001 Directives by Minister- Masking Requirements

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 184 (3)**
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:**
The licensee shall:

a. Perform audits, three times a week on two specified staff members, and other staff, for four weeks to ensure that they are following masking requirements appropriately while on resident units.

b. Document the audits and corrective actions taken based on audit results.

A written record must be kept of everything required under steps (a), and (b) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

**Grounds**
The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated and effective on November 7, 2023 when masking requirements were not followed by staff.

**Rationale and Summary:**
In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated and effective on November 7, 2023; licensees are required to ensure that the masking requirements as set out in this guidance document are followed. As one of the key defenses against the transmission of respiratory viruses, homes must ensure that all staff, students, volunteers and support workers comply with applicable masking requirements at all times. Masks are required to be worn in all resident areas indoors.

On a specified date in January 2024 the inspector was on the third-floor walking towards nursing station and saw a laundry aide with their mask down taking a drink. They finished drinking and still had mask under their chin when an RPN advised them to pull their mask up. They replied that the home wasn't on outbreak and that they didn't need to have it on, to which the RPN advised that they still did when they were on the unit. Inspector went to the second floor and immediately after getting off elevator, noted the same laundry aide from third floor in the nursing station with

their mask down under their chin speaking to someone. They looked over towards inspector, pulled mask up over their mouth and immediately left the unit via the stairwell.

On a specified date in January 2024, inspector noted a staff member in the nursing station on third floor with a surgical mask looped through and hanging from their left wrist. They were talking to a staff member for several minutes.

On a specified date in January 2024, inspector was in the dining room walking towards the dietary profiles and noted a dietary aide behind the serving counter with their mask under chin and immediately saw inspector and pulled their mask up.

Interview with IPAC lead #102 confirmed that all staff are to wear masks when on resident home areas and when near a resident on other areas.

Failure to comply with the masking requirements for masks to be worn on all resident areas indoors, places the residents at risk of transmission of infectious diseases.

**Sources:** Inspector #000721 observations, interviews with IPAC Lead #102, and other staff.
[000721]

**This order must be complied with by** March 12, 2024

## 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.