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
Sep 21, 2021	2021_823653_0023	009922-21, 011318-21, 013622-21	Complaint

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 Brampton
7891 McLaughlin Road Brampton ON L6Y 5H8

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 8-10, 13-15, 2021.

The following intakes were completed in this Complaint inspection:

Log #009922-21 was related to skin and wound care;
Log #013622-21 was related to residents' bill of rights, skin and wound care, continence care, and plan of care;
Log #011318-21 was related to Compliance Order (CO) #001 issued on July 16, 2021, within report #2021_872218_0010, related to the Ontario Regulation (O. Reg.) 79/10, s. 229 (4).

Critical Incident System (CIS) inspection #2021_823653_0024 was completed in conjunction with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the residents, a resident's Essential Care Giver (ECG), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Social Service Worker (RSSW), Resident Program Manager (RPM), Registered Dietitian (RD), Physiotherapist (PT), Housekeepers (HKs), Support Services Manager (SSM), Clinical Practice Leader (CPL), Skin and Wound Care Practice Leader (SWCPL), Infection Control Practitioner (ICP), Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, provision of care, staff to resident interactions, reviewed clinical health records, staffing schedules, staff education and training records, air temperature documentation, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Personal Support Services
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 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. 229. (4)	CO #001	2021_872218_0010	653

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's right to be treated with courtesy and respect, was fully respected and promoted by the staff.

A resident required staff assistance with care. On some occasions, the resident waited for more than half an hour for staff to respond to their call bell. When staff arrived in the resident's room, they would not normally provide an explanation for the delay in their response to the call bell. The resident did not feel good whenever this happened, as the resident was worried about sitting on a soiled brief for too long, which could negatively affect their skin integrity.

Seven out of 90 activations of the resident's call bell in a two-week period, showed that the staff did not respond to the call in a timely manner.

The Director of Care (DOC) reviewed the call bell audit records with the inspector, and acknowledged that the resident waited too long on some occasions, for staff to respond to their call bell.

Sources: Resident's callpoint detailed activity report; Interviews with the resident, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the DOC. [s. 3. (1) 1.]

2. The licensee failed to ensure that a resident's right to be properly groomed and cared for in a manner consistent with their needs, was fully respected and promoted by a PSW.

While receiving personal care, a resident complained to a PSW that the water was cold. The PSW did not respond to the resident and proceeded with providing care to them. The resident felt awful at that time, but did not want to argue with the PSW.

The RPN and the DOC indicated that the PSW should have changed the water or warmed up the water as preferred by the resident.

Sources: Resident's clinical health records; Interviews with the resident and their Essential Care Giver (ECG), RPN, and the DOC. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:
-Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity;
-Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

1. The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

The home's air temperature records from August 27, 2021, inclusive to September 5, 2021, for morning, afternoon, and evening, showed that the air temperatures in two resident rooms in different parts of the home, and the dining room and lounge on first and second floor, were not always maintained at a minimum temperature of 22 degrees Celsius.

Sources: Home's air temperature records, Interviews with the Resident Program Manager (RPM), and the Administrator. [s. 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the person designated by a resident, was given an opportunity to participate fully in the implementation of their plan of care.

On one occasion, a resident had asked their ECG to stay in the room while the PSWs provided personal care to them. However, a PSW refused to provide care to the resident with the ECG present in the room. The PSW stated to the resident and the ECG that only two staff members and the resident were allowed to be in the room at one time due to physical distancing requirements.

The home's Infection Control Practitioner (ICP) and the DOC indicated that the resident had the right to have the ECG stay in the room as long as the ECG did not impede care.

Sources: Resident's clinical health records; Interviews with the resident and their ECG, PSW, the ICP, and the DOC. [s. 6. (5)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing care to two residents, was held at least annually, to discuss the plan of care and any other matters of importance to the residents and their Substitute Decision-Makers (SDMs).

The Ministry of Long-Term Care (MLTC) received a complaint regarding a resident's annual care conference not held in 2020.

The resident's scheduled interdisciplinary team care conference assessment was cancelled in October 2020, and the Registered Social Service Worker (RSSW) confirmed that the care conference was not re-scheduled.

Sources: Resident's clinical health records; Interviews with the ICP, and the RSSW. [s. 27. (1)]

2. A resident did not have an interdisciplinary team care conference held in 2020, and the last one they had prior to 2020, took place in October 2019.

The RSSW checked their documentation records and confirmed that the resident's annual care conference was missed in 2020.

Sources: Resident's clinical health records; Interview with the RSSW. [s. 27. (1)]

Issued on this 22nd day of September, 2021

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

Original report signed by the inspector.