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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 27, 2023	
Inspection Number: 2023-1332-0002	
Inspection Type: Complaint	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Brampton, Brampton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.03.13 14:42:03 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 2-3, and 6-10, 2023.

The following intake was inspected:

- Intake #00015765, related to improper care.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that a resident's symptoms indicating the presence of infection were monitored in accordance with the Ministry's COVID-19 Guidance for Long-Term Care Homes (LTCHs).

The COVID-19 Guidance Document for LTCHs in Ontario, effective June 11, 2022, and updated on December 23, 2022, required homes to abide by the requirements set out in the COVID-19 Guidance Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units effective June 27, 2022, and updated on October 6, 2022, and January 18, 2023.

Rationale and Summary

The COVID-19 Guidance Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units effective June 27, 2022, and updated on October 6, 2022, documented that during a suspected or confirmed outbreak, homes should continue to conduct enhanced symptom assessment of all residents minimum twice daily to facilitate early identification and management of ill residents.

The home's Coronavirus (COVID-19) policy, documented that registered staff were to assess the residents as clinically indicated, including vital signs, chest assessment including listening to breath sounds and COVID-19 screening.

During a COVID-19 outbreak at the home, a resident was symptomatic and tested positive for the virus. The resident's oxygen saturation level was below the required range and oxygen therapy was initiated. The physician ordered antiviral therapy and monitoring of the resident's oxygen saturation levels. The antiviral therapy was initiated the next day.

During the duration of treatment for COVID-19, the resident's oxygen saturation levels and other vital signs, excluding temperature, were not monitored consistently as required.

The home's IPAC Lead and a Registered Practical Nurse (RPN) said that during a COVID-19 outbreak, residents who tested positive for the virus, should have had vital signs checked twice daily during the isolation period, in addition to monitoring for COVID-19 symptoms. The IPAC Lead also said the resident should have been assessed according to the home's COVID-19 policy.

Additionally, the home's physician said that during COVID-19 antiviral therapy, the resident's vital signs should have been checked to detect any saturation levels below the normal range that could have been indicative of onset of complications and the physician should have been informed.

Not following the directions related to enhanced symptom assessment during the COVID-19 outbreak as specified in the Ministry's COVID-19 protocol, might have contributed to the late detection and

treatment of symptoms associated with low oxygen saturation levels.

Sources: a critical incident (CI), a resident's clinical records, the home's Coronavirus (COVID-19), policy (September 2022), COVID-19 Guidance Document for Long-Term Care Homes (LTCH) in Ontario, (June 11, 2022), The COVID-19 Guidance Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (June 27, 2022) and (October 6, 2022), and interviews with a RPN, the home's IPAC Lead, the physician and other staff. [758]

WRITTEN NOTIFICATION: Housekeeping

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to comply with the housekeeping procedures for cleaning and disinfection of contact surfaces in three residents' rooms.

Rationale and Summary

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that the housekeeping procedures for cleaning and disinfecting of contact surfaces are complied with.

The home's Resident Room/Washroom Cleaning policy documented that the housekeeping staff should use a disinfectant cleaner and a clean cloth for cleaning high touch surfaces in residents' rooms including, but not limited to door handles, light switches, bedrails, call bells and cords, bed controls, telephones, bedside table and dresser tops, over-bed table, window sills, and alcohol based hand rub dispensers.

The home's Managing COVID 19: Phase 2 Operations guide for Extendicare, documented that all housekeeping staff were to disinfect high touch surfaces daily if the home was not in outbreak.

A housekeeper was observed cleaning three resident rooms and did not clean or disinfect high touch areas in these rooms.

The home's Environmental Service Manager (ESM) said that the high touch areas should have been cleaned daily when the home was not in an outbreak.

By not ensuring that cleaning procedures for high touch surfaces in resident rooms were followed increased the risk of spreading harmful microorganisms throughout the home.

Sources: observation of cleaning and disinfecting of resident rooms, the home's housekeeping policy (January 2022), the home's COVID-19 phase 2 guide (January 24, 2023) and interviews with a housekeeper staff, the home's ESM and other staff. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that assessments and interventions related to a resident's fluid intake and swallowing were documented.

Rationale and Summary

A resident was at nutritional risk due to low food and fluid intake, and risk for choking. The resident's plan of care documented that the resident would maintain a specific fluid intake daily. Staff were to encourage fluids at meals and snacks and monitor the resident for signs and symptoms of dehydration, difficulty swallowing and choking.

i) The physician ordered to monitor the resident's fluid intake for a specific period of time and inform the physician if the intake was low.

On two occasions, the resident had a fluid intake lower than their target.

There was no documentation of the assessments and interventions implemented. Additionally, there was no documentation of monitoring of the resident's fluid intake, except for one occasion during a day shift.

The home's Clinical Practice Lead and a RPN said the resident's assessments and interventions related to low fluid intake should have been documented.

ii) A resident was on a specific diet texture and fluid consistency. On one occasion, the resident's family requested a swallowing assessment due to concerns related to swallowing and pocketing of food. A referral was sent to the home's dietician on the same day.

A RPN said they directed staff to change the resident's diet to a different texture, monitor the resident for swallowing difficulties and notify the registered staff. There was no documentation of these actions and the resident's responses in relation to swallowing.

The resident was assessed by the home's dietician four days later, and their diet was changed to a different texture, pending a swallowing assessment.

The DOC said staff should have documented the interventions implemented and the resident's responses, as required.

Failing to ensure that the resident 's interventions related to fluid intake and swallowing difficulties were documented, increased the risk that the effectiveness of these interventions could not be evaluated.

Sources: a resident's clinical records, and interviews with two RPNs, Registered Dietician, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Medication Management System

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the written protocols for processing and discontinuing prescriber's orders were implemented for a resident.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 123 (1) and in reference to s. 123 (2), the licensee was required to develop written policies and protocols for the medication management system to ensure the accurate administration of all drugs used in the home.

The home's policy titled Pharmacy Services and Manual, documented the home would use the Pharmacy Policy and Procedures Manual as the first point of reference on medication management.

The pharmacy provider's manual documented that for new medications orders, the procedures in the Medication Administration Record (MAR) System were to be followed. Medications not procured from the pharmacy as well as nursing treatments and monitoring were to be entered by nursing staff. If a medication was discontinued, nursing staff were responsible for discontinuing medication on the MAR, according to the facility policy.

A. The procedure for processing new orders, documented that the first and second check should be completed by nurses during the confirmation of an order. The procedure for confirmation of an order, documented that after the order was entered in the eMAR by the pharmacy, the nurse should check all components of the order for accuracy, including the end date. If the order had a specific duration, nurses were to ensure the correct end date and time were entered before saving the order.

A medication was ordered for a resident for a specific period of time. The order was entered on the eMAR by the pharmacy and confirmed by an RPN on the same day. The end date of the order was not checked to ensure the correct end date and time were entered.

One dose of the medication was not entered in the eMAR, resulting in the resident missing their last dose of medication.

The home's Clinical Practice Lead and the Pharmacist Team Lead said the order was not processed as required.

Not following the steps outlined in the procedure for processing a new order, resulted in incorrect treatment duration and medication doses.

Sources: a resident's clinical records, email correspondence from the Pharmacist Team Lead, the home's Pharmacy Services and Manual policy, Manual for MediSystem Serviced Homes (June 2022), Processing New orders and Pending Confirmation of an Order procedures, and interviews with an RPN, the home's Clinical Practice Lead, the DOC, the Pharmacist Consultant and Team Lead.

B. The home's policy titled Physician/Nurse Practitioner Orders, documented that the physician's order form should be used to document all orders for pharmaceuticals, and other treatments for a resident. All the required steps for processing a physician's order including transcription and verifying accuracy of the order should be followed. The policy also documented two nurses should review the order for clarity and verify accuracy, initial and date. If a telephone order was received, the order should be reviewed for clarity and the physician should countersign the order on their next day in the home.

On one occasion, a resident had their oxygen saturation level below the normal range and oxygen therapy was initiated.

A physician's order was obtained to keep the resident's oxygen saturation levels in a specified range. Additionally, an antiviral therapy was ordered.

The order related to oxygen was entered on the eMAR, but it was not recorded on the physician's order form. The order was not checked and signed by a second nurse and was not countersigned by the physician. Additionally, the order did not include the frequency, duration of monitoring of the oxygen saturation levels and directions to be followed if the oxygen saturation levels were outside the ordered range.

The home's Clinical Practice Lead and the DOC said staff did not follow the procedure when they processed the physician's order. They also said the order was not clear as it did not include all the required components and the physician should have been contacted to clarify the order.

By not ensuring the physician's order was processed as specified in the home's policy, appropriate monitoring and interventions could not be implemented if the resident's oxygen levels decreased below the normal range.

Sources: a resident's clinical records, the home's Physician/Nurse Practitioner's Orders (January 2022), and interviews with two RPNs, the home's Clinical Practice Lead, the DOC and other staff.

C. The home's policy titled Management of Insulin, Narcotics and Controlled drugs, documented that the discontinued narcotic along with the individual resident's narcotic and controlled substances count sheet should be removed and placed in the designated area pending destruction from the pharmacy.

A physician's order was obtained to discontinue a resident's order for a regularly scheduled opioid.

The order was processed by two registered staff on the same day, but it was not discontinued on the eMAR until three days later, and the opioid was not removed from the medication cart after being discontinued.

The resident received one extra dose of the opioid on the same day it was discontinued. The error was not discovered until after the home's discussion with the inspector.

The home's Clinical Practice Lead said the order should have been checked and not signed by the two nurses until it was discontinued on the eMAR.

The home's DOC said when the medication was discontinued, it should have been removed from the medication cart and placed for destruction.

By not following the written protocols for discontinuing physician's orders related to narcotics, the resident was at risk of improper administration of opioid medications.

Sources: a resident's clinical records, Manual for MediSystem Serviced Homes (June 2022), the home's policy Management of Insulin, Narcotics and Controlled Drugs (January 2022), and interviews with two RPNs, the home's Clinical Practice Lead, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Administration of Drugs

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A. A Resident's pain medication regimen included scheduled and as needed opioid.

On one occasion, the resident was observed drowsy. The physician was notified and ordered to discontinue the resident's scheduled opioid. However, the resident received their scheduled dose of opioid the same day it was discontinued.

The home's Clinical Practice Lead and the DOC said the order to discontinue the opioid medication was not followed as required.

By not following the directions as prescribed by the physician increased the risk for harmful side effects associated with incorrect opioid administration.

Sources: a resident's clinical records, shift change monitored medication count in one RHA, and interviews with two RPNs, the home's Clinical Practice Lead and the DOC.

B. A resident was symptomatic and antiviral therapy was ordered for a specified period of time.

The correct number of doses was received from the home's pharmacy provider. There was no record of the last dose of administration on the resident's eMAR.

By not administering the antiviral medication as prescribed by the physician, there was a potential risk associated with incomplete antiviral therapy.

Sources: a resident's clinical records, packing slip for Extendicare Brampton for one RHA and interviews with an RPN, the home's Clinical Practice Lead, the DOC and other staff. [758]