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: August 16, 2024

Inspection Number: 2024-1332-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Brampton, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2-5, and 8-11, 2024

The following intakes were inspected:

- Intake #00115074 regarding concerns about a resident's skin and wound management.
- Intake #00116724 regarding concerns about a resident's care and support services.
- Intake #00116390 regarding the home's pain management program.
- Intake #00117537 regarding an Acute Respiratory Infection (ARI) outbreak.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Pain Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Duty to protect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

The licensee must be compliant with FLTCA, 2021, s. 24 (1).

Specifically the licensee shall:

1. Ensure weekly audits are completed for four weeks to ensure staff are completing skin and wound assessments as set out in the licensee's Skin and Wound Management Policy.
2. The audits should include:

a) The date and time of the initial skin and wound assessment.

b) Whether the skin and wound assessments were completed, name of the assessments, location and time completed, and the name of the person who completed them;

c) The date and time the referral was sent to Wound Care Nurse and Registered Dietitian

d) The date and time the Power of Attorney (POA) and (Medical Doctor (MD) was

notified;
e) The date and time weekly skin assessment and wound assessment completed including the progression of wound;
f) The name of the person who completed the above audit; and
g) A description of the follow up actions taken when there was a gap identified from the audit and the date the follow up actions were taken.

Grounds
The licensee has failed to ensure that a resident was protected from neglect by staff.

The Ontario Regulation 246/22 defines neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary
A complaint was received regarding a resident's skin and wound care management.

The Wound Care Nurse (WCN) stated that when the area of altered skin integrity was first identified, registered staff should have initiated treatment and sent a referral to them at that time.

A referral to the Registered Dietitian (RD) was not initiated by the registered staff until the resident's altered skin integrity had worsened further. This would allow for further assessment and implementation of any nutritional needs.

Skin and wound assessments were back dated. Due to the lack of documentation in the resident's clinical records in real time, and missing documentation, it was difficult to determine when the altered skin integrity was first identified and when

the altered skin integrity worsened. Registered staff did not follow the home's skin and wound policy as the altered skin integrity was not photographed using the home's specific skin and wound IPAD app to monitor the altered skin integrity. In addition, the physician was not notified immediately when the altered skin integrity worsened and there was evidence of the altered skin integrity worsening further.

The resident was placed at risk when registered staff failed to initiate skin and wound assessments, immediate treatment and follow up with the WCN and RD to manage and prevent the resident's altered skin integrity from worsening.

Sources: a resident's clinical records, the long-term care home's (LTCH)'s investigation notes, hospital notes and interviews with registered staff, the wound care nurse, physician and ADOC. [000687]

This order must be complied with by This order must be complied with by
September 9, 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.