Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West Service Area Office
609 Kumpf Drive, Suite 105
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Original Public Report

Report Issue Date June 29, 2022
Inspection Number 2022_1377_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare Halton Hills, Georgetown

Lead Inspector
Janet Groux (606)

Additional Inspector(s)
Deborah Nazareth (741745) was present during this inspection.

Inspector Digital Signature
Janet Groux
Digitally signed by Janet Groux
Date: 2022.07.15 10:02:09 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 24-27, May 30-31, and June 1-2, 2022.

The following Critical Incident System (CIS) and Complaint intake(s) were inspected:

- Intake #006713-22 related to the home's falls prevention and management program,
- Intakes #003819-22 related to an allegation of improper care and neglect to a resident; and intake #007464-22, a Complaint related to a resident's care.

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Care and Services
- Safe and Secure Home
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

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WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: LTCHA, 2007 s. 6(4)(a)

The licensee has failed to ensure registered staff collaborated with the physician when two residents had changes to their health condition.

A) Rationale and Summary:

A resident had a fall and sustained a serious injury.

The home's policy directed the registered staff to notify the physician when the resident had an onset of new or worsening pain.

The resident was assessed by a Registered Practical Nurse (RPN) with no injury or pain after they fell. The following shift, the resident woke up, restless and agitated.

A Personal Support Worker (PSW) said the resident was restless and agitated and said they could tell the resident was in pain.

A Registered Nurse (RN) said the resident did not sleep the remainder of the shift.

Medical and nursing interventions to calm the resident and help them sleep were initiated but were not effective.

The next day, the resident continued to exhibit signs of agitation and discomfort. An RPN observed the resident with injuries to areas of their body. The RPN noted that the resident's physical status had declined. A pain assessment was completed for the resident and identified the resident with a high pain level.

The RPN said when a resident had pain that was worsening, they were to notify the Physician. They acknowledged they did not call the physician. The Director of Care (DOC) said the physician should have been called.

Sources: the home's pain policy, a resident's progress notes, falls and pain assessments, and interviews with staff. (606)

B) Rationale and Summary:

A resident was observed with blood in their urine.

The home's policy on urinary tract infections directed the registered staff to notify the physician when the resident had symptoms of a urinary tract infection (UTI) including blood in the urine for further analysis and management.

The resident's SDM requested for staff to follow up with the physician for further treatment. There was no documentation in the resident's clinical records that the physician was notified.

An RPN acknowledged that the physician was not notified.

Failure to communicate to the physician about the two residents' changes in their health conditions prolonged and contributed to the residents' discomfort and delayed the follow up care for the two residents.

Sources: the home's policy on urinary tract infections, a resident progress notes and interviews with staff. (606)

WRITTEN NOTIFICATION: PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6(5)

The licensee has failed to ensure a resident's Substitute Decision Maker (SDM) participated fully in the development and implementation of the resident's plan of care.

Rationale and Summary:

A resident had changes to their health condition. Documentation did not identify that staff notified the resident's SDM of the changes in the resident's health condition.

Two RPNs said they were required to call and inform a resident's SDM whenever the resident had a change in their health condition. They acknowledged the resident's SDM was not informed of the changes to the resident's health condition.

Sources: a resident progress notes, assessments, and interviews with staff. (606)

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: Ontario Regulation 79/10, r. 30(2)

The licensee failed to ensure that an intervention to manage a resident's risk of falls was documented.

Rationale and Summary:

A resident had a fall and sustained a serious injury.

The resident's falls management care plan deemed them at high risk for falls. The care plan directed staff to check and make sure the specified falls prevention intervention for the resident had been implemented.

A PSW and an RPN said they checked to make sure the resident's falls prevention intervention was implemented at the beginning of the shift. They acknowledged that the checks to ensure the intervention was implemented throughout the shift were not documented.

Sources: a resident's progress notes, care records, falls management care plan, and interviews with staff. (606)

WRITTEN NOTIFICATION: COOLING REQUIREMENTS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 r. 23(4)(a)

The home failed to ensure that the heat related illness prevention and management plan for the home was implemented.

Rationale and Summary:

A heat advisory was issued by Environment and Climate Change Canada, for the area in which Extendicare Halton Hills was located.

The home's policy said that when a heat advisory was issued, staff were to implement the following: closing doors, windows, drapes, blinds during the day; and turning off lights to reduce the temperatures in residents' rooms.

Communication to the staff was posted in several areas of the home and said "Heat Alert", today's forecasted outdoor temperature 30-35 degrees Celsius. Outdoor temperatures are forecasted to be above 26 degrees Celsius. Reminder to please follow the home's policy.

Observations were completed during the heat alert days. Staff did not implement the required interventions to ensure the windows, drapes and blinds were closed during the day, and the lights in the residents' rooms were turned off.

A resident was in their room and observed in bed covered with several blankets. The window, and drapes were left open, and the lights in the room and bathroom were left on.

Three rooms were observed with the curtains and windows left open, and several lights were on in the room and bathroom. The residents who resided in these rooms were identified at high risk for weather related illnesses. An RN acknowledged that staff should make sure curtains and windows were closed, and lights were turned off in the residents' rooms.

Sources: observations during the heat alert days, the home's policy on Preventing Heat-Related Illnesses, and interviews with staff. (606)

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WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

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

Non-compliance with: O. Reg. 79/10 s. 68(2)(e)

The licensee has failed to comply with the system to obtain a re-weigh of a resident's weight.

In accordance with O. Reg 79/10 s. 8(1)(b), the licensee is required to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter, and must be complied with.

Specifically, staff did not comply with the home's policy on height and weight monitoring which was captured in the licensee's Nutrition and Hydration Program.

Rationale and Summary:

A resident had a significant weight change.

The home's policy said registered staff would compare the current weight by the seventh of the month with the resident's previous month's weight. Any weight with a 2.5 kilogram (kg) difference from the previous month required a re-weigh to ensure accuracy. The nurse would direct care staff to re-weigh the resident.

A resident had a significant weight change compared to the previous' month's weight. The resident's clinical records did not identify that a re-weigh was obtained.

An RPN said the resident had a significant weight change compared to the previous month's weight and acknowledged they did not ask the staff to re-weigh the resident.

Failure to obtain a re-weigh of a resident could put the resident at risk to receive care and interventions that may not have been appropriate for their nutritional needs.

Sources: the home's policy on height and weight monitoring, a resident's progress notes, weight records, and interviews with the staff and Registered Dietitian (RD). (606)