Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 30, 2023	
Inspection Number: 2023-1323-0001	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay	
Lead Inspector Sharon Connell (741721)	**Inspector Digital Signature**
Additional Inspector(s) Nicole Jarvis (741831)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17 - 21, 24 - 28, and 31, and August 1, 2023.

The following intake(s) were inspected:

- one for a staff to resident abuse,
- two for a staff to resident neglect,
- one for a resident fall
- one for resident-to-resident sexual abuse.

An additional seven intakes were completed in this inspection related to falls.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (a)

The licensee failed to ensure that registered staff collaborated in the assessment of resident #007 so that their assessments were integrated, and were consistent with, and complemented each other.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to a complaint from resident #007's substitute decision maker (SDM) alleging neglect of the resident in the month leading up to their transfer.

Over a period of days prior to transfer, resident #007's medical condition declined. The resident's clinical record detailed symptoms of illness including lethargy, excessive sweating, poor appetite, and confusion.

Decreased alertness and abnormal vital signs, prompted the first call to the physician, on the twelfth day of illness, resulting in transfer of the resident for care and treatment of their illness.

The Registered Practical Nurse (RPN) confirmed that registered staff were expected to fax the doctor and arrange for an assessment when concerns developed related to a resident's medical condition.

The RPN and Infection Prevention and Control Manager (IPAC) Manager confirmed that it was best practice to call a physician when concerned about a resident's ongoing illness, and document actions taken in the progress notes.

The IPAC Manager acknowledged that resident #007's medical decline should have been reported to the physician sooner than 12 days.

By failing to ensure that registered staff worked together to ensure assessments were integrated, consistent, and complemented each other, the licensee put resident #007 at risk of medical complications related to delayed diagnosis and treatment.

Sources: CIR, clinical records, interviews with RPN, IPAC Manager, resident #007 and SDM. [741721]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: Fixing Long-Term Care Act, (FLTCA), 2021, s. 24 (1) and Long-Term Care Homes Act (LTCHA), 2007, s. 19 (1).

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under LTCHA, 2007, s. 19 (1). Non-compliance also occurred after April 11, 2022, which falls under FLTCA 2021, s. 24 (1).

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

1. The licensee has failed to ensure resident #003 was protected from abuse by PSW #112.

Section 2 of the Ontario Regulation 246/22 defines "physical abuse" as (a) the use of physical force by anyone other than a resident that causes physical injury or pain,

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director regarding alleged staff to resident physical abuse.

The CIR detailed that resident #003 told PSW #114 that their impaired skin integrity had occurred when they were pulled out of bed by PSW #112. During the investigation the resident shared that the PSW was strong, and they did not think it was deliberate. The resident expressed their preference for gentler staff to provide their care.

During the investigation period the preceding Administrator confirmed that PSW #112 continued to provide care to residents post interview with the Director of Care (DOC), and that according to policy they should have been off work pending the outcome of the investigation into the resident's injuries.

The licensee failed to protect resident #003 and all residents, when PSW #112 continued to provide resident care during the physical abuse investigation period.

Sources: CIR, investigation notes, clinical records, Administrator interview. [741831]

Non-compliance with: LTCHA 2007, s. 19 (1)

2. The licensee failed to protect resident #005 from sexual abuse by resident #004.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director alleging resident #004 sexually abused resident #005.

Both the after-hours call and the CIR described that resident #004 was found in their under clothes in resident #005's room. Resident #005 was lying awake on their soiled bed, exposed to the waist and had an unusual expression on their face.

Camera footage showed resident #004 leaving their room, walking to resident #005's room, and closing their door. PSW #129 entered the room one and a half hours later and escorted resident #004 back to their room.

The DOC confirmed that 15-minute safety checks for resident #004 were initiated after a prior incident of sexual abuse towards another resident, and one to one (1:1) observation was implemented as per the care plan. Records showed that neither of the interventions were in place at the time of the incident.

PSW #102 recalled that 1:1 monitoring for resident #004 was unassigned, and only happened if the resident aide was willing to stay.

The IPAC Manager indicated that 1:1 monitoring, and safety checks were required for resident #004 at the time of the incident. After reviewing a two week sample of the safety check sheets, they confirmed that the records were incomplete and this was unacceptable.

The DOC confirmed that the records showed 1:1 monitoring for 12 hours on the day of the incident, despite the requirement for ongoing 1:1 monitoring.

PSW #129 was terminated after providing inaccurate information during the investigation and failing to complete the safety checks during the shift when the sexual abuse incident occurred.

Failure to protect resident #005 from resident #004's actions put them at risk for physical and emotional harm.

Sources: Clinical records, investigation documents, camera footage notes, and staff interviews (PSW #102, IPAC Manager, DOC). [741721]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (ii)

The licensee failed to ensure when resident #007 exhibited altered skin integrity, that they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director related to a complaint from resident #007's substitute decision maker (SDM) alleging neglect of the resident in the month leading up to their transfer.

Progress notes documented that resident #007’s substitute decision maker (SDM) had informed the RPN that a dressing for altered skin integrity had not been changed for more than three days. The Registered Nurse (RN) looked through the treatment administration records (TAR) and found that dressings were coded by the agency RN as being done by a PSW on two consecutive dates, which was not in the PSW’s scope of practice. The RN noted that agency staff were to be advised that dressing changes are to be done by registered staff only.

The TAR directed registered staff to cleanse and dress resident #007’s altered skin integrity, every other day. When the RN discovered that the dressings had not been changed for five days, they failed to change them, and the dressings remained unchanged for another 24 hours.

Resident #007 recalled that the new staff did not know they were supposed to change the dressings, so when they complained that it had not been done for a couple of days, they came and did it.

The SDM expressed concern about increased infection risk as a result of missing dressing changes, due to resident #007’s medical history. The RN assured the SDM that dressings would be done after they expressed their frustration that five days had elapsed with no dressing change and there had been no opportunity to communicate with the Administrator. The RN advised them that the wound care would be increasing to daily, because the wounds were getting worse.

The resident’s care plan outlined that registered staff were to complete daily dressing changes and monitor for signs and symptoms of infection and implement appropriate plan of care.

Six days elapsed before the dressings were changed as per the TAR. The subsequent skin and wound progress note documented an incomplete description of the wound and indicated resident had experienced pain in the area.

By failing to ensure that resident #007, who was exhibiting altered skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, the licensee placed the resident at risk for worsening skin breakdown and infection.

Sources: Clinical records, and interviews (SDM and resident #007). [741721]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 229 (5) (a)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director related to a complaint from resident #007's substitute decision maker (SDM) alleging neglect to the resident in the month leading up to their transfer.

SDM #117 expressed concern that the resident #007 was caused harm when the home neglected their illness symptoms in the month leading up to their transfer. They recalled from their notes that the resident was experiencing symptoms of illness affecting multiple body systems.

Resident #007 described that they were slowly not feeling right, which was out of the normal for them, recalling that staff thought it was odd that they were so tired.

In the 12 days prior to transfer, resident #007’s medical condition declined. Registered staff wrote progress notes every 24 to 48 hours indicating that the resident was experiencing symptoms of illness affecting multiple body systems.

Progress notes showed 24-to-48-hour gaps in documentation of the resident’s symptom monitoring despite two separate initial notes by registered staff acknowledging that monitoring would be required.

RPN #110 acknowledged that ill residents were supposed to be checked each shift. The RPN did not recall being trained to write on the 24-hour symptom line list and did not remember doing that.

RPN #125 confirmed there were issues with shift-to-shift communication at the time of resident #007’s illness. Registered staff were expected to follow up on issues from the prior 24 hours followed by recording any assessments, changes in medical condition, or referrals in the progress notes.

Progress notes for resident #007 during their illness period lacked documentation of shift-to-shift monitoring.

The IPAC Manager acknowledged that resident #007’s illness symptoms met the criteria of a suspected infection related illness, and registered staff were not performing shift to shift monitoring, and they should have been.

By failing to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and prevailing practices, the licensee put resident #007 at risk for medical complications related to delayed diagnosis and treatment.

Sources: CIR , clinical records, 24-hour Unit Reports, Daily 24-hour Symptom Surveillance Forms, staff interviews (RPN #110 and #125, IPAC Manager), resident #007 and SDM interviews. [741721]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 229 (5) (b)

The licensee failed to ensure that on every shift, the symptoms were recorded, and that immediate action was taken as required.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director related to a complaint from resident #007's substitute decision maker (SDM) alleging neglect to the resident in the month leading up to their transfer.

SDM #117 expressed concern that resident #007 was harmed by staff when their lack of care and inaction, related to the resident’s symptoms of illness, resulted in a worsening medical condition, and pain, requiring transfer out for treatment.

Resident #007 described that they were slowly not feeling right, which was out of the normal for them, recalling that staff thought it was odd that they were so tired.

In the 12 days prior to transfer, resident #007's medical condition declined. Registered staff wrote progress notes every 24 to 48 hours indicating that the resident was experiencing symptoms of illness affecting multiple body systems.

Registered staff did not document any follow up when the written and faxed physician referrals were unanswered on days 6, 8 and 11 of the resident's illness. The Administrator confirmed that the physician was unaware of the referrals, and there was no record of a physician assessment at that time.

RPN #110 confirmed that registered staff were expected to check ill residents every shift, fax or phone the physician if there was a significant change, and then document their actions.

RPN #125 confirmed that the symptoms documented in the first two days of resident #007's illness period warranted a phone call to the physician and family, to notify them of the change in medical condition and this was not done.

The IPAC Manager confirmed that resident #007's documented symptoms met the criteria of a suspected infection related illness and registered staff did not follow the home's policy.

Immediate action did not take place until the twelfth day of illness, when registered staff called the physician to report resident #007's abnormal vital signs and change in alertness. The resident was then transferred out and diagnosed with an infection that required treatment.

By failing to ensure that on every shift, the symptoms were recorded, and that immediate action was taken as required, the licensee put resident #007 at risk for medical complications related to delayed diagnosis and treatment.

Sources: CIR, clinical records, 'Reducing Avoidable Hospital Transfers' Policy, staff interviews (RPN #110 and #125, IPAC Manager), resident #007 and SDM interviews. [741721]

WRITTEN NOTIFICATION: Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary:

An agency worker was contracted to provide direct care to residents as a personal support worker (PSW #112) working in different home areas throughout their three month placement. A Critical Incident Report (CIR) was submitted to the Director, alleging staff to resident physical abuse involving PSW #112.

The Quality and Risk/IPAC Manager confirmed that all staff members were to complete the required training before performing their duties and there was no record of this training for PSW #112.

By failing to ensure that PSW #112 received training before providing direct resident care, the licensee placed the health and safety of residents at potential risk.

Sources: CIR, staff records, Quality and Risk/IPAC Manager interview. [741831]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure staff use safe transferring and positioning devices or techniques when assisting resident #003.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director regarding alleged staff to resident physical abuse.

The CIR indicated resident #003 was observed to have altered skin integrity and confirmed that it occurred during a repositioning activity performed by PSW #112.

Resident #003 confirmed that the PSW #112 had used a pulling motion, more than once, when helping them to move. They confirmed that they are no longer being transferred that way and the PSW no longer works at the home.

According to the investigation records, the DOC had provided education and reminder to PSW #112 on proper transferring techniques for the resident.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting resident #003, which caused a physical injury.

Sources: CIR, investigation notes, interviews with resident #003, and preceding Administrator. [741831]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure resident #003's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director regarding alleged staff to resident physical abuse.

The CIR indicated resident #003 was observed to have altered skin integrity.

The RPN had documented and confirmed during the inspection interview, that post incident they had completed a head-to-toe assessment, identifying the location of the altered skin integrity and noted that weekly skin assessments would be required.

According to the home's wound care management policy the nurse or wound care lead must assess all residents exhibiting altered skin integrity, promptly upon initial discovery, using a clinically appropriate assessment tool and re-assess at minimum every seven days.

No documentation of weekly skin assessments was found during record review. The next routine quarterly skin assessment noted no areas of impairment.

By failing to ensure resident #003 was reassessed at least weekly by a member of the registered nursing staff, the licensee put resident #003 at risk of unidentified worsening skin integrity.

Sources: Wound Care Management policy, clinical records, RPN interview. [741831]