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

Original Public Report

Report Issue Date: October 30, 2024	
Inspection Number: 2024-1323-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay	
Lead Inspector Inspector	**Inspector Digital Signature**
Additional Inspector(s) Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1-4, 7-11, and 15, 2024.

The following intake(s) were inspected:
Intake: #00124676 Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management

Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a resident's specific interventions were implemented as per their plan of care.

Rationale and Summary
A proactive compliance inspection (PCI) for the skin and wound program was completed at the long-term care home (LTCH). The resident's clinical records

indicated that they were to have a specific intervention implemented. During an observation, it was noted that the resident did not have the specified intervention implemented. A Registered Nurse (RN) and a Registered Practical Nurse (RPN) both indicated that the resident required the specified intervention. The RN indicated that the resident required the specified intervention for the prevention and management of altered skin integrity. The RN further indicated that specified intervention was always implemented, however, as the resident just finished physiotherapy and the staff may have forgotten to provide the specified intervention after removing it for therapy. The RN immediately provided the resident with the specified intervention. A follow up observation conducted on a different day indicated the resident received the specified intervention.

As a result of the resident not receiving the specified intervention was at risk for worsening of the altered skin integrity.

Sources: The resident's care plan; interviews with the RN and RPN; Observations

Date Remedy Implemented: October 11, 2024

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond to the Residents' Council in writing within 10 days

of receiving advice by the Residents' Council of concerns or recommendations.

Rationale and Summary
As part of a proactive compliance inspection, residents' council meeting minutes from period of September 2023 to August 2024 were reviewed. There were a number of concerns and/or recommendations that were advised by the Residents' Council. There was no record of written responses addressed to the Residents' Council relating to the advice received by the home.

The Administrator indicated that all advice received were responded verbally at the time of receipt. They were not aware that written responses addressed to the Residents' Council were required when the advice was received by the home.

Failure to respond the Residents' Council in writing within 10 days of receiving advice on concerns or recommendations impact opportunity for the Residents' Council to review, discuss and provide input into the licensee's action plans.

Sources: Residents' Council meeting minutes, interview with the Administrator.

WRITTEN NOTIFICATION: Powers of Family Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to respond to the Family Council in writing within 10 days of

receiving advice by the Family Council of concerns or recommendations.

Rationale and Summary
As part of a proactive compliance inspection, family council meeting minutes from period of September 2023 to June 2024 were reviewed. There were a number of concerns and/or recommendations that were advised by the Family Council established in the home. There was no record of written responses addressed to the Family Council relating to the advice received by the home.

The Administrator and Director of Care (DOC) both indicated that there were no written responses addressed to the Family Council related to the advice received. The DOC indicated that advice received were responded verbally at the time of receipt. They were not aware that written responses addressed to the Family Council were required for all advice received by the home and indicated that written responses would be done moving forward.

Failure to respond the Family Council in writing within 10 days of receiving advice on concerns or recommendations impact opportunity for the Family Council to review, discuss and provide input into the licensee's action plans.

Sources: Family Council meetings minutes, and interviews with the Administrator, DOC and a Family Council member.

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of

the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident received a bath twice a week.

Rationale and Summary
As part of a proactive compliance inspection, the resident care for two residents was reviewed.

Review of clinical record showed that staff documented "resident refused" for a resident's bathing on a specific date. There were no identified attempts to provide bathing assistance to make up for the missed bath as scheduled on the specified date. The resident received their next bath as scheduled on a twice a week basis that was four days later.

Interview with the DOC indicated that there were no identified baths that were made up for the missed bath on the specified date. Interview with the DOC and an RPN both indicated that the resident was to receive scheduled baths twice weekly on days. The RPN indicated that they were not sure the reason why it was missed during the day. The DOC and the RPN both indicated that the resident should have received a make up bath when their scheduled bath was missed.

Failure to ensure that a resident received bathing twice weekly at minimum affects personal hygiene, and quality of life.

Sources: clinical record, interviews with the DOC and staff.

WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to ensure that pain management program's policy to monitor two residents' responses to, and the effectiveness of, the pain management strategies was followed.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure pain programs policy to monitor residents responses to, and the effectiveness of, the pain management strategies are complied with.

Specifically, the staff did not follow Long-Term Care Home's (LTCH) pain policy which required multiple pain assessments to be completed when two residents had breakthrough pain medication for 3 consecutive days.

Rationale and Summary
1) A PCI for the pain program was completed at the LTCH. A resident's clinical records indicated that there was an assessment for pain on a specific date, related to an injury. The residents medication administration record indicated that the resident required breakthrough drug therapy for pain daily for a number of days. A standing dose of the drug therapy was started on a later date, reducing the breakthrough drug therapy requirement by the resident in a two month period.

The LTCH's pain program policy indicated that a pain assessment that reviews the following areas needs to be completed for 72 hours on every shift: Reason for assessment, location of pain, provocation of pain, quality of pain, whether the pain radiates and the timing of the pain. The DOC and Resident Assessment Instrument (RAI) Coordinator (RC) indicated that the pain assessment used in the home was located in the electronic health records.

In separate interviews, the RC and the DOC, indicated that a pain assessment was to be completed on every shift when three consecutive days of breakthrough pain medication is administered, and that for the resident, this was not completed when the resident had breakthrough pain medication daily for a number of days.

As a result of not completing consistent and comprehensive pain assessment there was a risk of not treating the residents pain appropriately.

Sources: Clinical records for the resident; Pain Identification and Management policy; Interviews with the DOC and the RC.

Rationale and Summary
2) A resident's clinical records indicated that there was an assessment for pain on a specific date related to a health condition. The residents medication administration record indicated that the resident required breakthrough drug therapy for pain daily for a number of days.

The LTCH's pain program policy indicated that a pain assessment that reviews the following areas needs to be completed for 72 hours on every shift: Reason for assessment, location of pain, provocation of pain, quality of pain, whether the pain radiates and the timing of the pain. The DOC and the RC indicated that the pain

assessment used in the home is located in the electronic health record.

In separate interviews, the RC and the DOC, indicated that a specific pain assessment was to be completed on every shift when three consecutive days of breakthrough pain medication is administered, and that for the resident, this was not completed when the resident had breakthrough pain medication daily for a number of days.

As a result of not completing consistent and comprehensive pain assessment there was a risk of not treating the residents pain appropriately.

Sources: Clinical records for the resident; Pain Identification and Management; Interviews with the DOC and the RC.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The licensee failed to ensure that the a system to monitor and evaluate the food and fluid intake was applied to a resident.

Specifically, when the resident's fluid intake was below the resident's individual fluid

target, a progress note related to the lack of fluids was not made as required by the LTCH's policy.

Rationale and Summary
A PCI for the dining and hydration program was completed at the LTCH. A review of the resident's clinical records indicated that the resident had an individualized fluid target of a specific amount. The resident's clinical records indicated that the resident fluid intake for a number of specific dates was below the resident's individualized fluid target amounts.

The LTCH's Food and Fluid intake monitoring policy required for the registered staff to take into account all other sources of fluid intake and make a progress note indicating why a hydration assessment was not completed. This was not noted in the progress notes during the identified time period. This information was confirmed by the DOC and an RPN.

As a result of not documenting in the progress notes whether a resident required a hydration assessment, the possibility of conducting hydration assessment would decrease, as a result the resident would be at risk for not receiving early intervention.

Sources: the resident's clinical records; Food and Fluid Intake Monitoring policy; Interviews with the DOC and an RPN.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee did not ensure that Additional Precautions were followed in the infection prevention and control (IPAC) program in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes revised September 2023" (IPAC Standard). Specifically, a staff member did not follow additional personal protective equipment requirements including appropriate selection, application, removal and disposal as was required by Additional Requirement 9.1 for Additional Precautions (f) under the IPAC Standard.

Rationale and Summary
As part of a proactive compliance inspection, practices in infection prevention and control program were reviewed. A Personal Support Worker (PSW) was observed selecting and applying personal protective equipment in front of a resident's room with point-of-care signage indicating that droplet and contact additional precautions were in place. The PSW was observed putting on a mask, gown, eye protection and gloves without performing hand hygiene.

Interview with the PSW indicated that they were made aware of recommended steps of selecting and putting on personal protective equipment but acknowledged that they performed it in the wrong sequence. They indicated that to remove the personal protective equipment they would remove gloves, gown, mask, eye protection and then perform hand hygiene. Interview with an RPN and IPAC

Manager indicated that there was a risk of contamination when appropriate personal protective equipment application and removal were not followed.

Failure to ensure that a staff member followed additional personal protective equipment requirements including appropriate selection, application, removal and disposal impacts infection control measures.

Sources: observation, interviews with a PSW, an RPN and IPAC Manager.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident were recorded.

Rationale and Summary
As part of a proactive compliance inspection, practices in infection prevention and control program were reviewed. The resident began presenting symptoms of infection on a specific date. Review of clinical record indicated that there was missing shift documentation that monitored symptoms of infection for the resident on a number of days.

The IPAC Manager indicated that symptoms of infection should be recorded in the resident's clinical record every shift and on a specific surveillance tool.

Failing to record symptoms for a resident impacts monitoring and timely response to any changes in condition.

Sources: The resident's clinical records, surveillance tool, interview with the IPAC Manager.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the report on the continuous quality improvement initiative for the fiscal year contained a written record of the dates the actions were implemented and the outcomes of these actions for any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents based on the home's priority areas for quality improvement during

the fiscal year.

Rationale and Summary
As part of a proactive compliance inspection, the continuous quality improvement initiative was reviewed. The home's report for the continuous quality improvement initiative did not contain record of the dates when actions were implemented to improve the accommodation, care, services, programs, and goods provided to the residents based on the home's active priority areas for quality improvement.

The IPAC Manager indicated that they were the Quality Lead. The IPAC Manager indicated that the report on the continuous quality improvement initiative did not contain any dates of when actions were implemented that addressed the home's active priority areas for quality improvement.

Sources: Quality Improvement Plan Narrative for Health Care Organizations in Ontario, and interviews with the IPAC Manager.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure that a copy of the report for the continuous quality improvement initiative was provided to the Residents' Council and Family Council.

Rationale and Summary

As part of a proactive compliance inspection, the continuous quality improvement initiative was reviewed. A review of the Residents' Council and Family Council meeting minutes did not indicate that the report for the continuous quality improvement initiative was provided to the Residents' Council and Family Council.

The Administrator indicated that a copy of the report for the continuous quality improvement initiative was not provided to the Residents' Council and Family Council.

Failure to provide a report on the continuous quality improvement initiative for the home to Residents' Council and Family Council impacts the engagement of stakeholders in the effort to improve care and services.

Sources: meeting minutes from Residents' and Family Councils, interview with the Administrator.