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

Hamilton District
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Original Public Report

Report Issue Date: July 10, 2024

Inspection Number: 2024-1369-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Mississauga, Mississauga

Lead Inspector	**Inspector Digital Signature**
Stephany Kulis (000766)	Stephany Kulis Digitally signed by Stephany Kulis Date: 2024.08.02 10:59:00 -04'00'

Additional Inspector(s)
Emma Volpatti (740883)
Liesl Florentino (000840)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12-14, 17-21, 24, 2024

The following compliant intakes were inspected:

- Intake: #00112787 - Complaint regarding resident plan of care related to pain management.
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The following Critical Incident (CI) intake were inspected:

- Intake: #00111370 - CI 2884-000004-24 - Injury to resident.
- Intake: #00112645 - CI 2884-000006-24 - Fall of resident resulting in injury.
- Intake: #00112834 - CI 2884-000007-24 - Improper/Incompetent treatment and pain management.

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

Resident Care and Support Services
Infection Prevention and Control
Pain Management
Falls Prevention and 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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident.

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident in relation to their Personal Assistance Services Device (PASD).

Rationale and Summary
The Physiotherapist (PT) assessed the resident for the use of a device for positioning as a PASD. Review of the resident's care plan, which all staff have access to, did not

identify the wheelchair as a PASD.

The home's policy titled Personal Assistance Services Devices indicates that the resident's care plan should state the purpose and timeframe for the use of any PASD.

The DOC acknowledged that the residents care plan did not include the purpose and timeframe for the use of the PASD and should have.

The care plan was updated to reflect the use of the PASD, it's purpose and associated timeframe.

Sources: Observations of the resident, resident's clinical record, the home's policy, and interview with the DOC.

Date Remedy Implemented: June 20, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

A) The licensee has failed to ensure that a resident's plan of care provided clear direction to staff and others who provided direct care to them.

Rationale and Summary
A resident had a transfer assessment completed which indicated that they required a specific level of assistance for all transfers. Review of their care plan indicated they required a certain lift for all transfers, which was verified by a staff member.

The DOC acknowledged that the plan of care was unclear in regards to the residents transfer status.

Failing to provide clear direction to staff posed a risk of an improper transfer.

Sources: Resident's clinical record, and interview with the DOC.

B) The licensee has failed to ensure that a resident's plan of care provided clear direction to staff and others who provided direct care to them.

Rationale and Summary
A resident's care plan indicated they were to receive pain medications as needed for pain. Review of their electronic medication administration record (eMAR) on that day indicated they did not have any pain medications prescribed to them.

The DOC acknowledged the direction was not clear to staff regarding pain medication.

Sources: Resident's clinical record, and interview with the DOC.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that that staff and others involved in the different aspects of a resident's care collaborated with each other in the development and implementation of the plan of care so that the different care aspects were integrated and consistent with and complemented each other.

Rationale and Summary
A resident's plan of care indicated that they required a range of assistance during locomotion. The PT's assessment stated that they required one specific level of assistance for locomotion. A resident's care plan did not reflect the PT assessment for mobility directions. The PT acknowledged that the different care aspects provided to the resident were not consistent with and did not complement each other.

Failing to ensure that the staff and others involved in the different aspects of a resident's care collaborated with each other in the development and implementation of the plan of care so that the different care aspects are integrated and are consistent with and complemented each other placed a resident at a greater risk for falls.

Sources: Resident's clinical record and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 the care set out in a resident's plan of care was provided to the resident as specified in the plan with regards to mobility.

Rationale and Summary
A resident's plan of care indicated that they required a specific level of assistance with locomotion. A staff member was assisting a resident with locomotion when they left a resident to attend to another resident. This resulted in a fall with injury.

The DOC acknowledged that the staff member did not follow the resident's plan of care relating to their required level of assistance for mobility.

Failing to follow the plan of care placed a resident at a greater risk for falls.

Sources: Resident's clinical record and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed in relation to pain management.

Rationale and Summary
One morning, a staff member documented that a resident was experiencing pain, with a pain score of six out of ten. They contacted the Nurse Practitioner (NP) to come and assess the resident. Later, the NP came to assess the resident and documented that the resident had pain with range of motion. No pain medication was ordered at that time for the resident.

In the evening, a staff member documented that a resident had a pain. The staff member acknowledged that they did not administer any pain medication to the resident at that time, and did not notify the physician (MD) or NP regarding the pain.

The following day, a staff member documented the resident's pain score was a two out of ten in the morning and in the afternoon, the resident's pain scale was a four out of ten. The staff member contacted the MD in the afternoon to obtain an order for pain medication. The staff member documented that the resident did not have any as needed or scheduled pain medications ordered for them.

Review of the residents clinical record indicated that no pain medication was administered to the resident when they were initially exhibiting pain. The home's investigation notes indicated that the staff member acknowledged that the resident was in pain and should have contacted the MD to obtain an order for pain

medication.
The DOC acknowledged that the staff did not review and revise the residents plan of care in relation to pain management interventions when they identified that the resident was exhibiting pain.

Failing to review and revise a resident's plan of care when their care needs changed posed a risk of unmanaged pain.

Sources: Resident's clinical record, home's investigation notes, and interview with other staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident began to exhibit pain and two days later it was confirmed through imaging that they had sustained an injury.

A resident's plan of care indicated they were to be transferred with a specific level

of assistance for all transfers. Review of the home's investigation notes indicated that, a staff member transferred the resident did follow the resident's transfer status. The staff member acknowledged that the transfer they performed was unsafe.

Failing to use a safe technique when transferring a resident posed a risk of injury.

Sources: CI report, resident's clinical record, the home's investigation notes, interview with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 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.

The licensee has failed to ensure the system to monitor and evaluate fluid intake for a resident was used.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure the written policy that deals with the procedure for staff to follow when residents do not meet their fluid targets was complied with.

Specifically, staff did not comply with the procedure for fluid intake monitoring in the food and fluid Intake monitoring policy.

Rationale and Summary
A resident had been identified as not meeting their fluid target as set out in their plan of care for 3 consecutive days and this was endorsed to oncoming shift.

According to the home's policy, if a resident consumes less than their individualized fluid target level for three consecutive days, the nurse must take into account additional fluids taken and chart rationale in progress notes for not completing a hydration assessment.

A staff member was aware of a resident's decreased fluid intake. According to the staff member, the resident did not show any signs of dehydration and was drinking so they did not document a follow-up of the rationale as to why assessment was not completed and stated they did not follow the policy.

Failure to document rationale may lead to delayed identification of dehydration in the resident.

Sources: Resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the

drugs.
The licensee has failed to ensure that when a resident was receiving antibiotics, the resident's response and the effectiveness of the antibiotics were monitored and documented.

Rationale and Summary
A resident started an antibiotic. A staff member stated when the resident was on antibiotic treatment staff were expected to document every shift. The Assistant Director of Care (ADOC) confirmed there was a lack of documentation to monitor the resident's response to/effectiveness of the antibiotics.

Failure to document the resident's response to the antibiotic put them at risk for delay in identifying a worsening infection.

Sources: Resident's record reviews; and interviews with ADOC and other staff.

WRITTEN NOTIFICATION: Resident records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record is kept up to date at all times.

Rational and Summary

A resident had a significant change. The resident's plan of care had multiple late entries including various assessments, progress notes, and physician assessments that were documented days after the significant change. A staff member stated they completed the assessment but did not document until days later. The DOC identified one of the areas of improvement in the resident's situation to be late documentation which jeopardized accuracy of events.

Failure to ensure written records are kept up to date at all times put the resident at risk of not having a comprehensive clinical picture of the events prior to the significant change

Sources: Resident's clinical records, home's internal investigative notes; and interview with staff.