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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 7, 2022	
Inspection Number: 2022-1175-0001	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Port Stanley, Port Stanley	
Lead Inspector Julie Lampman (522)	**Inspector Digital Signature** Julie Lampman Digitally signed by Julie Lampman Date: 2022.12.08 13:54:30 -05'00'
Additional Inspector(s) Karen Honey (740899)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 19, 20, 24, and 25, 2022

The following intake(s) were inspected:

- Intake: #00003590 related to improper/incompetent treatment of a resident.

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

Infection Prevention and Control
Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the type of bathing a resident received was documented.

Rationale and Summary

A resident's kardex indicated the resident's preferred method of bathing.

Review of the resident's Point of Care (POC) Documentation Survey report for a two month period, noted the documentation did not include the type of bathing the resident received. Also, on a specific date, there was no documentation to support that the resident had been bathed.

Personal Support Worker (PSW) #113 stated there was nowhere to indicate in POC whether a resident received a tub bath, shower or bed bath. PSW #113 stated the resident had not received their preferred method of bathing during the two month period.

Infection Prevention and Control (IPAC) Manager acknowledged there was no option in POC to indicate if resident had a tub bath, shower or bed bath.

Sources: A resident's clinical record and interviews with PSW #113 and the IPAC Manager.
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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
A resident had sustained an injury which required a specific treatment and monitoring.

A) A review of the resident's progress notes noted no documented assessments or monitoring of the resident.

Review of the resident's electronic Treatment Administration Record (eTAR) noted assessments were not initiated until eight days after the resident's treatment was initiated.

Registered Practical Nurse (RPN) #106 reviewed the resident's progress notes and eTAR with Inspector #522 and acknowledged assessments had not been initiated immediately when resident #001 sustained an injury and required a specific treatment.

The Infection Prevention and Control (IPAC) Manager stated when the resident sustained an injury and required a specific treatment they would have expected staff to complete assessments on the resident.

There was risk that the resident could develop complications related to their injury without regular assessments.

B) Review of the home's Skin and Wound Program: Prevention of Skin Breakdown policy noted specific preventative measures to preserve a resident's skin integrity.

A review of the resident's care plan noted no specific interventions for the resident to prevent skin break down and the resident developed an area of altered skin integrity.

Personal Support Worker (PSW) #113 stated that they would find information related to resident care in the resident's care plan or they were informed by the registered staff. PSW #113 stated there were no specific instructions related to the prevention of skin breakdown for the resident.

A registered staff member stated they updated the resident's care plan to include interventions to prevent skin breakdown, on the date the resident's altered skin integrity was discovered.

The Infection Prevention and Control (IPAC) Manager stated when the resident had a specific treatment initiated, registered staff should have updated the resident's care plan to include interventions to prevent skin breakdown.

The resident developed an area of altered skin integrity when their care plan was not updated with interventions to prevent skin breakdown.

Sources: Review of the resident's clinical record, the home's Skin and Wound Program: Prevention of Skin Breakdown policy #RC-23-01-01 dated December 2019 and July 2022, and interviews with PSW #113, registered staff members, the IPAC Manager and other staff.
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WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident had an initial skin assessment for an area of altered skin integrity.

Rationale and Summary
A resident developed an area of altered skin integrity.

Review of the resident's assessment tab in Point Click Care noted no documented assessment for the area of altered skin integrity.

A registered staff member stated skin assessments should be completed for the area of altered skin integrity. The registered staff member stated they had documented in the resident's progress notes that the resident had developed an area of altered skin integrity. The registered staff member confirmed that an assessment had not been completed for the area of altered skin integrity.

Sources: Review of the resident's clinical record and interviews with a registered staff member and other staff.
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WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 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 that a resident had weekly skin assessments completed for several areas of altered skin integrity.

Rationale and Summary
Progress notes indicated that a resident had developed several areas of altered skin integrity.

A weekly skin and wound assessment had not been completed on the resident during a specific week, for the areas of altered skin integrity.

A registered staff member stated they assisted the Wound Care Nurse to complete wound assessments weekly for the resident. The registered staff member acknowledged that wound assessments were not completed during a specific timeframe as the Wound Care Nurse was unavailable.

The Infection Prevention and Control (IPAC) Manager stated the areas of altered skin integrity should have been assessed even if the Wound Care Nurse was unavailable.

The absence of a weekly skin assessment of the resident's altered skin integrity increased the risk for complications due to altered skin integrity, however the resident experienced no adverse outcomes related to this non-compliance.

Sources: Review of the resident's clinical records and interviews with a registered staff member and the IPAC Manager.
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COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021, s. 24 (1).

The licensee must:
A) Develop and implement a process to ensure residents' reports received from external sources are:
i) Reviewed, signed, dated, and documented in the residents' electronic record by registered staff.
ii) The residents' plan of care is updated to reflect any orders or changes to care.
ii) Any reports, orders and changes to care are reviewed, signed and dated by the resident's attending physician.
iv) Resident reports include but are not limited to Consult Reports, Emergency Reports, and specific treatment instructions.

B) Develop and implement a process to ensure all registered staff and physician communication records related to resident care are retained i.e., physician's book.
C) All registered staff will receive training on the new processes. The training must be documented, including the names of staff members and the date the training occurred.
D) All registered staff that did not complete training on the home's revised Skin Policy dated July 2022, be trained on the revised skin policy. Training must be documented, including the name of the staff members and the date training occurred.

Grounds
The licensee has failed to ensure that a resident was not neglected by staff.

Rationale and Summary
O. Reg. 246/22, s. 7 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A Critical Incident System (CIS) Report was submitted to the Ministry of Long-Term Care by the home related to improper/incompetent treatment of a resident that resulted in harm to the resident.

i) A resident returned from an appointment with a treatment in place and instructions on the treatment were given to registered staff. Instructions indicated how the treatment was to be applied and specific care for the resident.

The resident's progress notes indicated the treatment had not been applied as per the instruction sheet. There was no documentation in the resident's progress notes that registered staff had consulted Physician #114 or the home's Physician #111 regarding how the treatment was applied.

A registered staff member stated at that time, the home did not have a process in place to care for a resident with the specific treatment. The registered staff member stated they did not follow up with Physician #114 to clarify how the treatment was to be applied.

ii) Physician #114's consult report indicated the resident was to have the treatment indefinitely and the resident's skin was to be checked daily. The consult note was not documented in the resident's progress notes and there was no indication on the date the report had been received and who had reviewed it. There was no order in the resident's electronic Treatment Administration Record (eTAR) for daily checks of the resident' skin and no documentation in the resident's clinical record that the resident's skin had been checked daily. The registered staff member stated they did not recall seeing Physician #114's

report related to the resident having daily skin checks.

The registered staff member stated the resident returned to the home with treatment instructions from Physician #114. The registered staff member stated they did not receive any orders regarding the treatment but had posted the treatment instruction sheet above the resident's bed.

Two registered staff members indicated there was no formal process in the home for receiving written reports or consult notes from physicians. The registered staff members stated the home's present process was based on the nurse reviewing any information received and then notifying the home's physician of any medication orders and then putting the report in the physician's book. One of the registered staff members stated they would also make a note in the resident's record of the information received.

iii) The home's Skin and Wound Program: Prevention of Skin Breakdown policy indicated staff should review the positioning and placement of medical devices to minimize pressure areas for residents with a Pressure Ulcer Risk Score (PURS) of 4 or greater. The resident was at risk for skin breakdown and there were no documented interventions in the resident's plan of care related to minimizing pressure from the treatment that had been applied.

Although Physician #114 ordered that the resident was to have daily skin checks, the resident did not have their skin checked for a three week period.

iv) Physician #111 visited the resident approximately two weeks after the resident had the treatment applied and noted that the resident had more pain. There was no documented assessment of the resident or indication that Physician #111 had inspected the resident's skin where the treatment had been applied.

On four occasions after the resident was seen by Physician #111, documentation noted the resident had pain and behaviours. There was no documented assessment of the resident's skin where the treatment had been applied.

Approximately three weeks after the treatment had been applied, a registered staff member discovered several areas of skin breakdown where the resident's treatment had been applied.

A treatment plan was developed for the resident, although the specific treatment was still not applied as per the treatment instructions.

Physician #111 expressed there was a break down in the resident's care as the resident's skin should have been inspected daily.

Physician #114 stated they had not received any follow up from the home that the resident's treatment had not been applied as per the instruction sheet. Physician #114 stated the way the treatment had been applied would cause the resident to develop altered skin integrity.

The IPAC Manager acknowledged that what had happened to the resident was due to a lack of communication and lack of knowledge.

The resident developed altered skin integrity when their treatment had been applied incorrectly for approximately three weeks. Staff neglected to follow up with Physician #114 for direction when they noted the treatment had not been applied as per the treatment instructions and instead consulted the Physiotherapist, who also did not consult Physician #114, and provided incorrect information. Staff also neglected the resident by not performing daily skin checks as ordered. When the resident displayed behaviors that could be associated with pain, staff still did not assess the resident's skin. When the areas of altered skin integrity were identified, staff still continued to apply the treatment incorrectly.

Sources: Review of the resident's clinical record, a CIS Report, the home's Skin and Wound Program: Prevention of Skin Breakdown policy #RC-23-01-01 dated December 2019 and July 2022, a specific treatment instruction sheet, consult reports and interviews with staff, Physician #111, Physician #114, the IPAC Manager.
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This order must be complied with by February 10, 2023

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.