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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: December 23, 2024

Inspection Number: 2024-1049-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Scarborough, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 3 - 6, 9 -11, and 13, 2024

The following Critical Incident System (CI) intake(s) were inspected:

- Intake: #00122548 - CI 2117-000026-24 - Related to injury of unknown cause.
- Intake: #00128653 - CI 2117-000027-24 - Related to responsive behaviours.
- Intake: #00129158 - CI 2117-000029-24 - Related to allegations of abuse.
- Intake: #00129484 - CI 2117-000030-24 - Related to injury of unknown cause and allegations of abuse.

The following Complaint intake(s) were inspected:

- Intake: #00124368 - Related to allegations of abuse and concerns around medication administration.

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

Resident Care and Support Services

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

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Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 has failed to ensure the safety precautions in a resident's plan of care were implemented as specified in the plan.

Rationale and Summary
A resident had a responsive behaviour and safety measures were added to their plan of care to prevent a reoccurrence.

Items that posed a safety concern were found in the resident's room by the inspector. The Behavioural Supports Ontario (BSO) Lead acknowledged the items should not be in the resident's room.

Failure to ensure the safety measures set out in the resident's plan of care are implemented, placed them at risk of harm.

Sources: Observations; resident clinical records; interviews with the home's staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a suspected resident abuse incident was immediately reported to the Director.

Rationale and Summary
The home received an email with allegations of resident abuse. The LTC Homes After Hours Reporting line was not called and the Critical Incident System (CIS) report was submitted late to the Director. The Director of Care (DOC) confirmed that the incident should have been reported immediately to the Director.

Failure to immediately report the suspicion of abuse of a resident could lead to the delay in response by the Director.

Sources: CIS report; interview with the home's staff.

WRITTEN NOTIFICATION: Pain Assessments

NC #003 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 has failed to appropriately monitor a resident's response to and the effectiveness of a newly implemented pain management intervention.

Rationale and Summary
A resident expressed severe pain and was sent to hospital. When they returned to the home, the resident was started on new interventions. The Pain Identification and Management policy stated that when a new pain intervention is started, pain assessments must be completed each shift for 72 hours. Pain assessments for this resident were not completed on two of the required days during day and evening shifts, which a Registered Practical Nurse (RPN) acknowledged.

Failure to complete pain assessments as per policy resulted in the risk of breakthrough pain not being captured, and decreased opportunity to implement interventions to address the resident's pain.

Sources: Resident clinical records; Pain Identification and Management Policy March 2023; interviews with the home's staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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 ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Specifically, section 7.3 (b) of the IPAC Standard for Long-Term Care Homes states to ensure audits are performed at least quarterly and to ensure that all staff can perform the IPAC skills required of their role.

Rationale and Summary
Review of the home's IPAC audits revealed that hand hygiene and PPE IPAC practice audits were not conducted at least quarterly to ensure that all staff can perform the IPAC skills required of their role. The IPAC Lead acknowledged that the IPAC audits to ensure all employees were capable of carrying out the IPAC skills necessary for their roles were not completed.

Failure to conduct IPAC practice audits decreases the opportunity to identify staff not adhering to IPAC protocols and implement interventions.

Sources: The home's IPAC audits, interview with IPAC lead.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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

1. Educate the home's leadership team on the zero tolerance of abuse and neglect policy, with a specific focus on the steps to be taken when an investigation is required based on the home's investigation guidance document.

2. Audit at least one abuse investigation conducted by home after the issuance of this order, based on the home's zero tolerance of abuse and neglect policy requirements. If there is no recent investigation conducted, audit an investigation that was conducted in the past six months. The audit must identify any gap(s) to which the investigation did not align with the home's abuse and neglect policy and the actions taken to address these gap(s).

3. Ensure DOC and/or a designate informs the specified residents, and/or their substitute decision maker (SDM) of the allegations of abuse, the home's investigation into their allegation of abuse and how the outcomes were reached. This step must be documented and include actions taken.

4. Educate specified RN on the reporting and response requirements based on the home's abuse and neglect policy.

5. Maintain a record of the education conducted in steps 1 and 4, and the audit conducted for step 2, including the dates the education and audit were completed, and person(s) who were involved in the process of providing the education and conducting the audits.

Grounds

The licensee failed to ensure that the home's written policy on reporting and responding to abuse and neglect of residents was complied with.

Rationale and Summary
i) A Registered Nurse (RN) witnessed suspected resident abuse by another staff and failed to immediately report and take action to respond to the suspected abuse in accordance with the home's abuse and neglect policy.

A review of the three residents' clinical records indicated no documentation, assessments, and interventions were implemented in response to the incident.

The home's abuse and neglect policy stated that any suspected abuse is to be reported immediately, assessments must be completed to ensure safety and accurate details are to be documented in the residents' charts.

The RN acknowledged that they should have immediately reported the suspected abuse, performed assessments on the residents impacted and documented the incident.

Failure to ensure staff report and respond to an allegation of resident abuse immediately may result in delays in the home's actions to protect residents from

abuse.

Sources: Home's abuse and neglect policy, residents' clinical records; interview with the homes staff.

ii) The home failed to investigate to allegations of abuse in accordance with their abuse and neglect policy.

The home's abuse and neglect policy stated that thorough investigation is to be initiated immediately upon notification of suspected abuse.

The home's investigation notes showed that the investigation was not initiated immediately and interviews with various witnesses and two of the residents named in the allegations were not documented in the home's investigation notes.

The DOC confirmed the investigation was not completed in accordance with the home's investigation guidance document, and that the home failed to immediately initiate the investigation.

Failure to take action to support and protect the alleged residents and complete an immediate and thorough investigation may result in the residents having a diminished sense of safety in the home.

Sources: Home's abuse and neglect policies, investigation notes, resident's clinical records, interviews with the home's staff.

iii). The home failed to notify the three residents' families, Power of Attorneys (POAs), and Substitute Decision Makers (SDMs) of the suspected abuse and outcome of the home's investigation as per their policy.

The home's abuse and neglect policies indicated that disclosure of alleged abuse

shall be made to residents' families, POAs, and SDMs immediately upon becoming aware and that communication and support shall be provided throughout the process.

The DOC could not provide information to support that disclosure of the alleged abuse and communication throughout the investigation process was provided to the families, POAs, and SDMs of the residents impacted.

Failure to disclose the allegations of resident abuse and communicate throughout the investigation process resulted in lack of transparency and accountability from the home to the residents' families, POAs, and SDMs.

Sources: Home's abuse and neglect policies, resident's clinical records; Interview with the home's staff

iv) The licensee failed to comply with their abuse investigation policy when a resident made an allegation of abuse.

The homes policy outlines several components required of an abuse investigation, all of which were not provided in the home's investigation notes, including interview notes, witness statements, collected evidence, analysis of evidence, recommendations, and a final report.

The ADOC acknowledged that the home's abuse investigation procedure was not followed.

Failure to conduct a thorough investigation into the abuse allegations resulted in a lack of accountability from the home and places the resident at risk of not feeling safe and protected.

Sources: Home's investigation notes, Investigation Toolkit November 2023,

Interview with the home's staff

This order must be complied with by February 12, 2025

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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.