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

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Original Public Report

Report Issue Date: August 30, 2024
Inspection Number: 2024-1472-0003
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Timmins, Timmins

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 21-24, 2024, and August 26, 2024.

The following intakes were inspected:

- One intake regarding an Enteric Outbreak.
- One intake regarding a fall resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management

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 (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.

The licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff and others who provided direct care to the resident related to their mobility needs.

Rationale and Summary
A resident had multiple falls, which changed their mobility status.

A physician's order specified how to ambulate the resident with a specific mobility aid due to their risk of falling.

According to the progress notes, the resident's ability to ambulate with the specific mobility aid, improved several days later.

The resident's care plan stated that because they were at risk of falling, they would use a different mobility aid than what was ordered as their primary mode of locomotion. The care plan also stated that specific staff members could assist the resident with ambulation, outside the resident's room and with the mobility aid specified in the physician's order. The care plan provided no information about the resident's mobility or use of mobility aids in their room.

Several staff members stated that the resident's mobility status was unclear. They acknowledged that the information about the resident's mobility was conflicting, and that when the resident's needs changed, the information should have been updated and clearly reflected in their plan of care.

Failure to ensure that a resident's written plan of care provided clear directions to staff put the resident at risk for future falls and injury.

Sources: A resident's health records; and interviews with the Assistant Director of Care and other staff members.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with, and complemented each other.

Rationale and Summary
A physician ordered a resident's transfer method on a specific date.

The following day, a physiotherapist assessed the resident and recommended an alternative transfer method.

Several days later, the progress notes indicated that staff members were transferring the resident using yet another transfer method.

A staff member stated that they initially transferred the resident using the physiotherapist's recommended method but changed it as directed by a registered staff member. A registered staff member stated that they were unaware of the physiotherapist's recommendations for a specific transfer method, so they transferred the resident based on their assessment of the resident's abilities.

Registered staff and the Assistant Director of Care (ADOC) acknowledged that the interdisciplinary team members should have collaborated in their assessments; failing to do so did not provide staff with clear direction on how to safely transfer the resident.

Failure to collaborate assessments between staff and others involved in a resident's care, put the resident's safety at risk due to unclear transfer directions.

Sources: A resident's health records, the licensee's policies titled, "Plan of Care", and "Safe Lifting with Care"; and interviews with the ADOC and other staff members.

WRITTEN NOTIFICATION: Plan of care

NC #003 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 that the care set out in the plan of care was provided to a resident as specified in their plan of care.

Rationale and Summary
A resident's care plan stated that due to a risk of falls, staff were to use a specific fall prevention intervention at specific times.

During the inspection, the resident was observed twice without the fall prevention intervention in place, as indicated.

Several staff members confirmed that the care plan was not followed, and that staff were expected to implement the falls prevention interventions as outlined in the care plan.

Failure to ensure that the falls interventions outlined in the resident's care plan were implemented as specified in the plan, increased the resident's risk of harm.

Sources: Observations of a resident; a resident's care plan, and the licensee's policies titled, "Plan of Care" and "Falls Prevention and Management"; and interviews with staff members.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that a resident was reassessed when there was a change in their condition.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the falls prevention and management program at a minimum, provided for strategies to reduce or mitigate falls and was complied with.

Specifically, the staff failed to comply with the licensee's falls prevention and management program policy which required them to complete a specific assessment.

Rationale and Summary
The home's policy titled, "Falls Prevention and Management Program", outlined the nursing staffs' responsibility to conduct a specific assessment whenever a resident's condition changed.

A resident fell which changed their condition. The specified assessment of the resident was not completed.

Registered staff and the ADOC acknowledged that the specified assessment should have been completed after the resident's condition had changed but it was not.

Failure to ensure that a resident received a specific assessment when their condition changed, put the resident at risk of not receiving the appropriate level of care.

Sources: A resident's health record, the licensee's policies titled, "Falls Prevention and Management Program" and "Safe Lifting and Care"; and interviews with the ADOC and registered staff members.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 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 complied with.

Additionally, in accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies for IPAC were complied with. Specifically, staff did not comply with the licensee's policy on personal protective equipment (PPE) audits.

Rationale and Summary
The licensee's "Personal Protective Equipment" policy required the home to conduct PPE audits to ensure donning/doffing compliance and appropriate PPE use/selection. The policy identified a minimum number of nursing and non-nursing observations to be conducted during both non-outbreak and outbreak situations.

A review of the audits provided by the home over a set period of time revealed that the number of audits completed did not comply with the home's policy, nor were the positions of the audited staff documented.

The IPAC Lead acknowledged that the staff PPE audits were not being completed

as required.

Failure to ensure that the home's PPE audits were completed as required may have increased the risk of infection transmission by preventing any gaps in practice from being identified and addressed.

Sources: PPE audits provided by the home; licensee's policy titled, "Personal Protective Equipment", Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, April 2024, and the IPAC standard for Long-Term Care Homes (LTCHs), revised September 2023; and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The licensee has failed to ensure that the home complied with the outbreak management system.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols developed for the outbreak management system

were complied with. Specifically, staff did not comply with the licensee's policy for declaring an outbreak.

Rationale and Summary
The licensee's policy titled, "Declaring an Outbreak", stated that the IPAC Lead must be aware of case definitions and declare an outbreak when symptoms met the criteria for an outbreak. In addition, they were to notify the local public health authority of the suspected outbreak immediately.

The line listing for an outbreak in the home stated that isolation for a symptomatic resident began on a specific date. Two days later, the home identified additional symptomatic residents, but they were not reported to the public health unit (PHU) until the next day.

The IPAC Lead acknowledged that the PHU was not notified as required.

Failure to ensure that the licensee's policies for declaring an outbreak were followed, may have put other residents at risk of exposure to suspected or identified infectious agents.

Sources: Line listings for Outbreak, the licensee's policies related to outbreak management; and an interview with a Public Health Inspector and the IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following

incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed no later than one business day following an incident that caused an injury to a resident which resulted in a significant change in their health status.

Rationale and Summary
A resident fell several times, was taken to the hospital, and returned to the home with a significant change in their health status.

A critical incident (CI) report for the falls could not be located.

The ADOC confirmed that a CI report regarding the falls was not submitted to the Director.

Failure to report to the Director as required may have put the resident's safety at risk due to a lack of transparency with the Director.

Sources: A resident's health records, the home's investigation file, the home's risk management reports, and the licensee's policy titled, "Critical Incident Reporting"; and an interview with the ADOC.