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

North District
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Original Public Report

Report Issue Date: October 4, 2024
Inspection Number: 2024-1668-0003
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC LP, by its general partners, Axium Extendicare LTC GP Inc. and Extendicare LTC Managing GP Inc.
Long Term Care Home and City: Extendicare Countryside, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16-20, 2024

The following intake(s) were inspected:
- A complaint related to alleged neglect of a resident;
- One intake related to the breakdown of a major system;
- One intake related to a fall of a resident which caused an injury;
- A complaint related to care concerns of a resident; and,
- One intake related to neglect of a resident.

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control

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 (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 was reassessed, and the plan of care reviewed and revised when resident's care needs changed.

Rationale and Summary
A resident was observed with a specific intervention in place. The care plan and Kardex did not contain any information related to the specific intervention. The Director of Care (DOC) and a Registered Nurse (RN) verified that the intervention remained in effect and should have been added to the care plan. The resident's care plan was updated by the RN to include the specific intervention.

There was a low risk to the resident as the intervention was implemented although

not listed in the care plan or Kardex.

Sources: Observations of a resident; current care plan and Kardex; interviews with a PSW, RN, and the DOC.

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) (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 has failed to ensure that the staff and others involved in the different aspect of care of a resident collaborated with each other in the development and implementation of the plan of care so that different aspect of care was integrated, consistent and complemented each other.

Rationale and Summary
A resident returned to the home after being hospitalized. The transfer report identified post hospitalization care for the resident which were not implemented or communicated to the resident's health care team. The RN acknowledged they should have better communicated with other staff members of the resident's care needs when the returned to the home from the hospital.

There was risk of harm to the resident.

Sources: Interview with RNs and DOC; Review of transfer report and interview notes between an RN and DOC, Physician's order.

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure a resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A resident sustained an incident for which the SDM was made aware of four days after the occurrence instead of the same day. The DOC and RN acknowledged that the resident's SDM should have been notified of the incident on the day it occurred.

There was a low risk to the resident when the resident's SDM was notified four days after the incident occurred.

Sources: a resident's specific assessment form and progress notes; Interviews with an RN and the DOC.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 has failed to ensure that care was provided to a resident as specified in the resident's plan of care.

Rationale and Summary
A resident who was at risk of falling had specific intervention in their care plan to mitigate the risk of falls. During observations, it was noted that an intervention was not in place. The DOC confirmed that the intervention should have been in place as it was included in the resident's plan of care.

There was risk to the resident when an intervention listed in their care plan to mitigate the risk of falls was not implemented.

Sources: Observations of a resident; a resident's care plan; interviews with a PSW, an RN, and the DOC.

WRITTEN NOTIFICATION: Reporting and Complainants

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent care of a resident that resulted in harm or risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Concerns about a resident's care were raised by a resident's SDM. The Assistant Director of Care (ADOC) stated that the incident had not been reported to the Director.

No harm was caused to the resident when the incident was not reported to the Director.

Sources: interview with ADOC, and DOC; record review of a Critical Incident System (CIS) report and tip sheet for reporting.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 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 the home's falls prevention and management program which provided for strategies to reduce or mitigate falls was followed for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidents of falls and the risk of injury and that it was complied with. Specifically, staff did not comply with the home's policy.

Rationale and Summary
A resident was observed without a fall intervention which was listed in their plan of care. The home's falls prevention and management policy indicated that an interdisciplinary team would flag for additional interventions in the prevention of falls and injury. The DOC acknowledged that the resident should have had a specific intervention in place as indicated in the care plan.

There was no harm to the resident when staff didn't implement all strategies to reduce or mitigate falls as per the home's falls prevention and management program as the resident had no further falls since the implementation of the intervention.

Sources: Observations of a resident; Interviews with a PSW, an RPN and DOC; Record review of a resident's current care plan for fall prevention and management, home's policy titled, "Falls Prevention and Management",

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A progress note described a that resident had a fall in their room. The Inspector could not locate a post fall assessment related to the fall. A further review of post fall assessments identified that there were three additional post fall assessments that were not fully completed.

An RN stated that staff were to conduct a post fall assessment after every fall and it was to be fully completed. The DOC verified there were post fall assessments that were not completed or fully completed.

There was a moderate risk to not completing the post fall assessments as the resident was at risk of falling and continued to sustain falls.

Sources: A resident's post fall assessments; the home's Falls Prevention and Management Program policy and progress notes; interviews with an RN and the DOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by an authorized person.

Rationale and Summary
A resident returned from the hospital with a surgical wound. After the first wound assessment, no follow up assessments of the wound were completed. The RN stated that they should have entered the wound assessment in the treatment administration record as this would have prompted them to create a weekly wound assessment protocol to ensure weekly wound assessments would be completed.

There was risk of harm, however no harm came to the resident when the resident's surgical wound was not monitored weekly.

Sources: Interviews with an RN and DOC; record review home's policy titled, "Skin and Wound Program: Prevention of Skin Breakdown policy and physician's orders.

WRITTEN NOTIFICATION: Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee has failed to ensure that the home's interdisciplinary medication management system that provided safe medication management and optimized effect drug therapy outcome was followed.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a medication management system that provided safe medication management and optimized effective drug therapy. Specifically, staff did not comply with their policy when administering topical medications.

Rationale and Summary
A resident was ordered a topical medication. The RPN stated the PSW were to apply the topical medication.

The home's policy titled, "Transfer of Function/Delegation of Tasks- Topical Creams", which was included in the medication administration program, identified that the care provider was to be instructed by a nurse on the proper application of the ointment, following orders found in the Treatment Administration Record, (TAR). The nurse was to receive reports and supervise the care provided, monitor and ensure that the treatment was applied as per the resident's treatment assessment record. The ADOC stated that PSWs were not to apply medication creams to the residents as the home had not provided training for this task.

There was risk of harm to the resident when there was no monitoring of the application of the topical medication.

Sources: Physician's orders, a resident's care plan and home's policy titled, "Transfer of Function/Delegation of Tasks- Topical Creams"; Interview with complainant, an RPN and ADOC.