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

Central West District
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Original Public Report

Report Issue Date: February 16, 2024	
Inspection Number: 2024-1377-0001	
Inspection Type: Complaint and Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Halton Hills, Georgetown	
Lead Inspector Kailee Bercowski (000734)	**Inspector Digital Signature**
Additional Inspector(s) Katherine Adamski (753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 23-25, 29-31, and February 1, 6, 2024

The following intakes were completed in this complaint inspection:

- Intakes #00103285 and #00104402 regarding resident care.
- Intake #00105224 related to admissions.

The following intakes were completed in this critical incident inspection:

- Intakes #00102138/CI 2892-000044-23 and #00103807/CI 2892-000046-23 involving resident to resident abuse.
- Intake #00104402/CI 2892-000048-23 regarding resident care.
- Intake #00104479/CI 2892-000049-23 related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure that a resident's rights were fully respected related to proper accommodation, nutrition, care and services consistent with their needs.

Rationale and Summary
A resident was provided care that was not consistent with their needs and preferences related to continence, repositioning, and morning care.

Two PSWs stated they were aware of the residents' needs, however they did not provide the required care.

The resident's rights were not fully respected and put their safety at risk, when staff provided care that was not consistent with the resident's needs and preferences.

Sources: Video Surveillance Data (December 2023), a resident's clinical records, communication records involving the home's management, as well as interviews with the Acting Administrator and other staff.
[753]

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under the Continence Care and Bowel Management program, including interventions and the resident's responses to interventions, were documented.

Rationale and Summary
On multiple occasions in December 2023, PSWs documented providing continence care to a resident as per their plan of care.

Video surveillance footage showed that the continence care was not provided as per their plan of care.

The Director Of Care (DOC) stated that they expected staff documentation to accurately reflect the care provided to the resident.

Sources: Video Surveillance footage, a resident's clinical records, the home's investigative notes, communication records with management of the home, interviews with complainant, DOC and other staff.
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WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure actions taken for responding to the responsive behaviour needs of a resident were documented.

Rationale and Summary
Over a period of two weeks, a resident was prescribed four separate medication changes related to the management of their responsive behaviours. The changes included a 150% increase in their routine medication, and the introduction of a new daily medication. They were also prescribed two new antipsychotic medications for

use when the resident became agitated.

Shortly afterwards, the home's physician ordered two weeks of Dementia Observation System (DOS) documentation to evaluate the effectiveness of the intervention changes in the management of the resident's responsive behaviours.

During this period, the resident was administered their as needed medications several times, in addition to their routine medications. Throughout the month, staff documented a change in the resident's condition, including their intake, weight, and level of alertness.

At the time of inspection, the Behavioural Support Assistant was unable to provide completed DOS documents for the period of the medication changes, and said there have been challenges with staff compliance in completing DOS documentation.

When the DOS documentation was not completed as per the physician's order, the resident was at increased risk of an ineffective evaluation and delayed adjustment of their responsive behaviour interventions.

Sources: Interviews with the Behavioural Support Assistant, & other staff; a resident's clinical records.
[000734]

WRITTEN NOTIFICATION: Behaviours and altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure interventions were implemented to reduce the risk of potentially harmful interactions related to a resident's responsive behaviours.

Rationale and Summary
Staff were to use verbal strategies prior to initiating care with a resident who had identified triggers for resistance to care. If the interventions were ineffective, staff were directed to notify the unit nurse.

During the inspection, staff reported using physical strategies prior to initiating care for the resident, and were not aware of the resident's care needs related to their responsive behaviours.

When a resident's interventions for managing responsive behaviours were not implemented, they were at increased risk of a harmful interaction with staff.

Sources: Interviews with the Behavioural Support Assistant, & other staff; a resident's clinical records, and a Critical Incident Report.
[000734]

WRITTEN NOTIFICATION: Same, short-stay admission, respite care and convalescent care programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 179 (3)
Approval by licensee

s. 179 (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 51 (8) of the Act.
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 51 (9) of the Act to the persons mentioned in subsection 51 (10) of the Act.

The licensee failed to within five business days after receiving the request mentioned in clause (1) (b), to do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 51 (8) of the Act.
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 51 (9) of the Act to the persons mentioned in subsection 51 (10) of the Act.

Rationale and Summary
For approximately seven weeks between December 2023 and January 2024, the home did not admit any residents into the home's unoccupied beds.

On a date in December 2023, the Director of Patient Services at Home and Community Care Support Services (HCCSS) requested that Extendicare Halton Hills reconsider approving admissions into the home. The Acting Administrator acknowledged receiving the request from HCCSS and not taking any action in response to the communication.

In January 2024, there were a significant number of pending applications awaiting a response from the home.

In January 2024, the home had ten vacant beds.

The Acting Administrator and DOC acknowledged that the home had vacant beds and a backlog of applications awaiting a response from the home, however, they did not provide a rationale as to why the home had not had any new admissions between December 2023, and January 2024.

Despite the home's vacant beds and a significant number of pending applications, the home did not admit any new residents for approximately seven weeks. The applicants, their families, and the healthcare system were unduly burdened by the lengthy wait times.

Sources: Extendicare Halton Hills #54410 Detailed Monthly Census Report (December 2023, January 2024), Point Admission/Discharge Report (December 2023 to January 2024), Email Communications between HCCSS and Extendicare Halton Hills, Health Partner Gateway Application Data, interviews with HCCSS Director of Patient Services, Acting Administrator and other staff.
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WRITTEN NOTIFICATION: Duty to inform placement co-ordinator of vacancies

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 204
Duty to inform placement co-ordinator of vacancies
s. 204. Every licensee of a long-term care home shall, within 24 hours after a bed in the home is no longer occupied, inform the appropriate placement co-ordinator of the following:
1. That the bed is no longer occupied.

2. The class of accommodation of the bed.
3. Whether the bed is a class A bed.
4. Whether the bed is subject to a design manual applicable under a development agreement to which the home was subject.
5. The date on which the bed will be available for occupation.

The licensee failed to ensure that they informed the appropriate placement co-ordinator of four vacant beds within 24 hours after they were no longer occupied, of the following:
1. That the bed is no longer occupied.
2. The class of accommodation of the bed.
3. Whether the bed is a class A bed.
4. Whether the bed is subject to a design manual applicable under a development agreement to which the home was subject.
5. The date on which the bed will be available for occupation.

Rationale and Summary
On four dates in December 2023, four beds were not communicated to Home and Community Care Support Services (HCCSS) within 24 hours of the beds becoming vacant.

When vacant beds were not communicated with HCCSS, HCCSS was not able to co-ordinate admissions into the home from a significant number of outstanding applications pending a response from the home.

Sources: Extendicare Halton Hills #54410 Detailed Monthly Census Report (December 2023), Health Partner Gateway, interviews with HCCSS Director of

Patient Services, DOC and other staff.
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