Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 4, 2022
Inspection Number 2022_1343_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare Canada Inc

Long-Term Care Home and City
Extendicare Hamilton, Hamilton

Lead Inspector
Daniela Lupu (758)

Additional Inspector(s)

Inspector Digital Signature
Daniela Lupu
Digitally signed by Daniela Lupu
Date: 2022.08.16 17:24:27 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 11-15, and 18-22, 2022.

The following intake(s) were inspected:

- Log # 017959-21 (Complaint) related to staffing and nutrition and dietary services
- Log # 018576-21 (Complaint) related to resident care
- Log # 005695-22 (Complaint) related to abuse.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 54 (b)

The licensee has failed to implement interventions to minimize the risk of altercations and harmful interactions between residents.

Rationale and Summary

A resident had a history of responsive behaviours towards other residents and staff.

A specific intervention was discontinued for the day shift and staff were directed to monitor resident's behaviours and whereabouts.

In a three-day period, in separate occasions, this resident initiated altercations with three residents from the same home area.

On a fourth occasion, the resident initiated an altercation with a different resident from the nearby home area. As a result of this interaction, the affected resident was upset and did not feel safe when this resident was around them. The affected resident required clinical monitoring for three days to rule out potential injuries.

A Registered Nurse (RN) acknowledged that staff did not monitor the resident's whereabouts as required.

The behavioural intervention was not re-instated for the day shift until after the fourth incident with a resident.

The Director of Care (DOC) said staff were expected to monitor and know the resident's whereabouts.

Staff not implementing interventions to minimize risk of altercations between residents had a moderate impact on one resident and a potential risk of harm of other residents.

Sources: a resident's clinical records, and interviews with PSWs, a RN, and the DOC. [758]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 53 (4) (c)

The licensee has failed to ensure that a resident's responses to their responsive behaviours interventions were documented.

Rationale and Summary

A resident had multiple responsive behaviours towards residents and staff. The resident's plan of care directed staff to monitor and document the resident's behaviours and responses to the interventions to address these behaviours at specified time intervals on the home's monitoring tools.

i) In a two-week period, the documentation of resident's responsive behaviours showed several occasions when the documentation was not completed. Additionally, on multiple occasions the documentation was not completed at the specified time intervals, as required.

ii) A specific intervention was initiated to aid in the management of the resident's responsive behaviours. A monitoring tool was also initiated to document the resident's behaviours and responses to this intervention at specified time intervals.

In a two-week period, the monitoring tool showed multiple days and times when the documentation was not completed as required.

The DOC said the resident's behaviours should be documented as indicated in the resident's plan of care and the monitoring tool should have been completed entirely.

By not completing documentation of the resident's behaviours and their responses to the behavioural interventions as required, the effectiveness of the interventions could not be accurately evaluated.

Sources: a resident's clinical records and an interview with the DOC.

[758]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 23 (1) (a) (i)

The licensee has failed to ensure that an incident of alleged abuse of a resident, that was reported to the home, was immediately investigated.

Rationale and Summary

A written communication alleging abuse of a resident was sent to the home's Assistant Director of Care (ADOC).

The DOC said that the incident was not investigated, as required.

By not investigating the incident of a resident's alleged abuse, the cause of the incident could not be determined and interventions to mitigate the risk of reoccurrence could not be identified and implemented.

Sources: two residents' clinical records, a written communication with the home, and interview with the DOC.

[758]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) 2

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

On two separate occasions, two written communications alleging abuse of a resident were sent to the home's ADOC.

None of these incidents were reported to the Director.

The DOC said the allegations should have been reported to the Director immediately.

The home's failure to report to the Director immediately after becoming aware of the allegations of abuse of a resident, may have delayed the Director's ability to respond to the incidents in a timely manner.

Sources: two residents' residents clinical records, two written communications with the home, and an interview with the DOC.

[758]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.101 (2) (c)

The licensee has failed to ensure that a documented record that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required was kept in the home for a complaint alleging a resident's abuse.

Rationale and Summary

On two separate occasions, the home received two written complaints alleging a resident's abuse and concerns related to the resident's safety.

The home's complaint records did not include a copy of these complaints with the type of action taken to solve the complaint, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

The DOC said that a complaint form was not completed for any of these complaints as required.

Sources: the home's complaints record, a resident's clinical records, two written correspondences with the home, and an interview with the DOC.

[758]

WRITTEN NOTIFICATION: NUTRITION MANAGER

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 75 (1)

The licensee has failed to ensure that there was one nutrition manager for the home to lead the nutrition care and dietary services program for the home.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) alleging that the home did not have a nutrition manager.

The home did not have any records indicating that there was a nutrition manager for the home for five months.

The home's Administrator, the Resident Program Manager and the DOC acknowledged that the home did not have a nutrition manager on the above period as required.

The home's Administrator said that some of the challenges with food ordering and deliveries in the above period could have been minimized if a nutrition manager was in the home.

Sources: a complaint record, and interviews with the Administrator, Resident Program Manager, DOC and other staff.

[758]

WRITTEN NOTIFICATION: AIR TEMPERATURE

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

Non-compliance with: O. Reg. 246/22 s. 24 (1)

The licensee has failed to ensure that the home was maintained at minimum temperature of 22 degrees Celsius.

Rationale and Summary

During a 15-day period, the home's air temperature electronic reports showed that the air temperatures recorded in two resident rooms, one dining room area and the main lobby area were between 20 to 21.5 degrees Celsius on multiple days and times.

On a different 30-day period, the air temperatures electronically recorded in three resident rooms, two dining room areas and the main lobby were between 20 to 21.5 degrees Celsius on multiple days and times.

The home's Air Temperature logs, manually recorded in all residents' rooms, between 1200 hrs and 1700 hrs in a specified time period documented temperatures between 17.5 and 21.5 degrees Celsius on multiple occasions in multiple residents' rooms in all home areas.

The home's Support Services Manager (SSM) and the DOC said the air temperature should be maintained at minimum 22 degrees Celsius. The DOC said if the air temperature falls under 22 degrees Celsius corrective actions should be taken and documented.

There was no record of any actions taken in the above indicated period of time when the air temperature was not maintained at minimum 22 degrees Celsius.

By not maintaining the air temperature at a minimum 22 degrees Celsius, there was potential risk of negative outcomes to residents associated with low temperatures.

Sources: the home's electronic air temperature records, the home's air temperature logs recorded in the resident's rooms, and interviews with the SSM, DOC and other staff.

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

[758]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 229 (5) (b)

The licensee has failed to ensure that on every shift staff recorded a resident's symptoms of infection and took immediate action as required.

Rationale and Summary

A resident was at risk for infections due to their medical diagnosis. The resident's plan of care directed staff to monitor for signs and symptoms of infection and report to the registered staff every shift any abnormal findings including changes in the resident's condition.

The home's specific infection algorithm, documented that when signs of a specified infection were noted, staff were to implement specific interventions, monitor and assess the resident and discuss monitoring with the physician or nurse practitioner.

On one occasion, during the day shift, a Registered Practical Nurse (RPN) noted a change in a resident's condition and suspected that the resident had an infection. There was no documentation of any assessments completed. Additionally, there was no documentation of any monitoring of symptoms or assessments completed during the following evening and night shift.

The documentation of the resident's care indicated that the resident's condition started to deteriorate in the last two days.

The next day, during the day shift, a different RPN noted the worsening in the resident's condition. There was no documentation of the resident's symptoms, vitals signs, any assessments completed to address the resident's worsening in condition or the notification of the physician in the above indicated period of time.

At the end of the evening shift, the Charge Nurse and the physician were informed about the resident's worsening condition. The resident was transferred to the hospital and required treatment for the worsening of their condition.

The DOC said staff should have assessed, monitored and recorded the resident's symptoms every shift and notified the physician of the resident's condition.

Failing to implement immediate actions to address symptoms when an infection was suspected had a moderate impact on the resident as their treatment was delayed which might have contributed to the worsening in their condition**.**

Sources: a resident's clinical records, the home's assessment algorithm and pathway for infections, and interviews with a PSW, a RPN, and the DOC.

[758]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

A. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program and include proper use of Personal Protective Equipment (PPE), such as appropriate selection, application, removal, and disposal.

The home's PPE policy, documented that staff should follow PPE donning and doffing principles when providing care for residents, including disposing of all PPE in a hands-free garbage receptacle before leaving the resident's rooms.

i) On one occasion, a PSW exited a resident's room without removing their gloves after providing care to the resident. They disposed soiled items and continued to roll a hamper cart in the hallway without removing their gloves. The same PSW returned to the home area still wearing gloves and went towards the clean utility room where they touched the doorknob without removing their gloves.

On a separate occasion, on the same home area, a different PSW exited a resident's room without removing their gloves while carrying soiled items. They disposed the soiled items in the servery area and walked in the hallway towards the soiled utility room where they touched the doorknob without removing their gloves.

On a third occasion, on a different home area, a PSW walked in the hallway towards the soiled utility room with the gloves on while carrying a bag with soiled items. They touched the doorknob of the soiled utility room with their soiled gloves.

ii) The home's PPE doffing sequence signage and droplet and contact precautions were posted on a resident's room door. The PPE doffing signage documented gloves were to be removed first, followed by gown, eye protection and mask.

On one occasion, before exiting this resident's room, a PSW removed their eye protection while wearing gloves, then removed their gown and lastly their gloves.

The home's ADOC/IPAC Lead said that staff should remove PPE according with Routine and Additional Precautions procedures. Staff should remove gloves before exiting a resident's room and should not walk in the hallways with soiled items. They also said staff should have followed the PPE doffing sequence before exiting a resident's room with Additional Precautions in place.

Sources: observations of PPE use with routine and additional precautions, IPAC Standard (April 2022), the home's PPE policy and PPE doffing sequence signage, interviews with the home's ADOC/IPAC Lead and other staff.

B. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 6.1 indicates the licensee shall make PPE available and accessible to staff and residents, including having a PPE supply in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

On two separate occasions, there were no procedure masks in the PPE container outside of a resident's room where droplet and contact precautions were in place. On a different occasion, there were no procedure masks and eye protection in the PPE container outside of the same resident's room.

A PSW said that they could not change their N95 respirator before exiting the resident's room because there were no procedure masks available in the PPE container. They said they had to walk to the clean utility room to obtain a procedure mask.

A RPN said PPE supplies should be available at the point of care and PPE doffing sequence should be followed before exiting a resident's room with droplet and contact precautions in place.

Sources: observations of PPE use and availability at the point of care, IPAC Standard (April 2022), and interviews with two PSWs, a RPN and the home's ADOC/IPAC Lead

[758]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee has failed to ensure that the home carried out the policy directive for management of symptomatic individuals and PPE requirements when interacting with suspected cases of COVID-19.

In accordance with the Minister's Directive, COVID-19 response measures for long-term care homes, effective April 27, 2022, issued under the Fixing Long-Term Care Act, 2021, the licensee was required to ensure that case and outbreak management and personal protective equipment requirements were followed as set out in the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units and Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities.

Rationale and Summary

A**.** The Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, issued on June 27, 2022, requires that all symptomatic residents are tested for COVID-19, even during non-COVID outbreaks, using a laboratory-based molecular test or a rapid molecular test. Rapid antigen tests (RATs) have a significantly lower sensitivity for COVID-19 than molecular tests and should not be used routinely for residents who are symptomatic. Additionally, the residents who were exposed to COVID-19 should be tested using a laboratory-based molecular test on day five after their exposure.

Four residents were placed on droplet and contact precautions for reasons specified in the Ministry's Directive. Two of these residents were not tested using the required molecular tests and for the other two residents there was delay in testing.

A Public Health Inspector from the City of Hamilton said that the residents should have been tested using the required molecular tests.

By not following the testing requirements there was a potential risk that COVID-19 was not diagnosed accurately and in a timely manner.

Sources: four residents clinical records, the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units (June 27, 2022) and interviews with the ADOC/IPAC Lead, DOC and a Public Health representative from City of Hamilton.

B. The home's COVID-19 Universal PPE Strategy documented that the home should follow health authority, province, or local health unit specific directives, as they become available, for guidelines pertaining to the use of PPE.

The Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, version 1.0, June 10, 2022, requires that all health care workers providing direct care to or interacting with, a suspect or confirmed case of COVID-19 wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator or approved equivalent.

A resident was on droplet-contact precautions and their test results were unknown at the time of the inspector's observation. Staff were to wear N95 respirators before entering in the resident's room.

On one occasion, two PSWs entered this resident's room to provide care. One PSW donned a N95 respirator that they were not fit-tested for. The second PSW did not wear a N95 respirator before entering in this resident's room. Upon exiting the resident's room, the two PSWs did not change their mask or N95 respirator.

A PSW said the N95 respirator should be changed with a procedure mask before exiting a resident's room with droplet and contact precautions in place.

On a separate occasion, a different PSW donned a N95 respirator that they were not fit-tested for before entering in a different resident's room who was placed on droplet and contact precautions.

The home's list for fit-tested N95 respirators, documented that the two PSWs were fit-tested for different N95 respirators than they donned.

The home's ADOC/IPAC Lead said that staff should have used the N95 respirators that they were fit-tested. They said masks or respirators should have been changed as part of the PPE doffing procedure before exiting the resident's room where droplet and contact precautions were in place.

By not wearing the required N95 respirators when providing care as required there was a potential risk of spreading COVID-19 to other residents, staff and visitors**.**

Sources: observations of two residents' rooms**,** the Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, (June 10, 2022), the home's COVID-19 Universal PPE Strategy, the home's N95 respirators records, and interviews with a PSW, the ADOC/ IPAC Lead, the DOC and the PH representative from City of Hamilton.
[758]