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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 26, 2024	
Inspection Number: 2024-1071-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Oshawa, Oshawa	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 24, to 26, 29 to 30, 2024, August 1, to 2 and 6, to 8, 2024

The following intake(s) were inspected:

- a complaint related to dining services, housekeeping and alleged verbal abuse
- a complaint related to resident care
- a complaint related to safe and secure home
- a complaint related to alleged verbal abuse, and the resident bill of rights
- a Critical Incident Report (CIR) related to alleged verbal abuse, and the resident bill of rights
- a complaint related to responsive behaviours management

- a complaint related to maintenance services

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Residents' Rights and Choices

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) 1.

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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect.

Rationale and Summary

A complaint and a Critical Incident Report (CIR) were received by the Ministry of Long Term Care (MLTC). The complaint and CIR alleged that a resident had requested the list of attendees for an event and was informed that this information was 'not their business' by the Programs Manager. Investigation notes were reviewed, and the allegation was substantiated. The Programs Manager indicated that they informed the resident that the list of attendees contained the attendees contact information. The Programs Manager further indicated that they had told the resident that the list of attendees was 'not their business'. Progress notes indicated that the resident was visibly upset about the interaction with the Programs Manager.

Additionally, later when the resident attempted to attend the recreational event, they were denied attendance because their name was not on the list of attendees. The Programs Manager confirmed that the resident was denied attendance to the program because their name was not on the list. The Programs Manager also indicated that there was available space and that if there was no space available that the staff would still encourage residents to participate in the recreational programs.

The resident was not treated with courtesy and respect when they were denied attendance to the recreational event and during their interaction with the Programs Manager.

Sources: CIR, clinical records, complaint record, investigation file, and interview with the Programs Manager

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. i.
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:
19. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of their plan of care,

The licensee failed to ensure that a resident participated in the revision of their plan of care.

Rationale and Summary

A complaint was received by the MLTC. The complainant alleged that a resident was scheduled agency staff for their 1:1 which was changed to Extendicare staff. The resident, who was able to participate in other aspects of their care was not informed of the changes made to their 1:1 staffing. Nursing schedule and observations indicated that the resident no longer had agency 1:1 staff.

Associate Director of Care (ADOC) #111 indicated that they made changes to staffing without informing the resident, and that the resident should have been included.

Failure to include the resident in the revision of their plan of care resulted in decreased quality of life.

Sources: Nursing schedule, observations, and interviews with ADOC #111

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

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

Non-compliance with: O. Reg. 246/22, s. 59

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions for a resident.

Rationale and Summary

A complaint was received by the MLTC regarding a code white incident that occurred with a resident. A review of the resident's clinical record indicated that the resident had responsive behaviors and episodes of confusion and hallucinations on admission which were exacerbated when they had acute changes to their health status. A Dementia Observation System (DOS) was initiated for 7 days and was not completed in its entirety. There was no care planned focus, goals, or interventions to communicate that the resident had responsive behaviors to the staff in the care plan.

The Director of Care (DOC) and ADOC #111 indicated that the DOS monitoring was the appropriate tool used in the home to identify potential triggers and patterns for residents exhibiting responsive behaviours. The DOC further indicated that the DOS monitoring tool should have been completed when it was initiated to accurately identify triggers and patterns and that this information would then be care planned.

The resident's triggers and patterns of responsive behaviour were not identified due to the incomplete documentation of the DOS monitoring tool which resulted in no care planned interventions developed to ensure the safety of co-residents.

Sources: clinical records, interviews with the DOC and ADOC #111.

WRITTEN NOTIFICATION: Maintenance Services

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

Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee failed to ensure that procedures are developed and implemented to ensure that the ice machine was kept in good repair.

Rationale and Summary

A complaint was received by the MLTC regarding an ice machine that was broken. Maintenance records were reviewed and indicated that the ice machine dispensed metal and required repairs. RN #110, the DOC and Handyman #119 indicated that the ice machine was broken for approximately two weeks before it was repaired. RN #110 indicated that the resident informed them that they were promised bottled water while the ice machine was out of service and indicated that the resident was upset that this was not made available to them. RN #110 bought bottled water for the residents as an alternative.

Failure to keep the ice machine in working condition resulted in a decreased quality of life for the resident.

Sources: Maintenance records, interviews with staff, and the DOC

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (1)

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,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve;

(c) clear directions to staff and others who provide direct care to the resident; and

(d) any other requirements provided for in the regulations.

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

The licensee shall

The DOC or designate shall prepare, and implement a written plan for ensuring that residents of the convalescent care program with responsive behaviors have their behavioral triggers and strategies to mitigate altercations identified in their plan of care.

The DOC or designate shall prepare, and implement a written plan for ensuring that residents of the convalescent care program with known alcoholism have this identified in their plan of care.

Grounds

The licensee failed to ensure that there was a written plan of care that set out

(a) the planned care for the resident;
(b) the goals the care is intended to achieve;
(c) clear directions to staff and others who provide direct care to the resident; and
(d) any other requirements provided for in the regulations

Rationale and Summary

A complaint was received by the MLTC. The complaint involved a resident's alcohol storage, and an incident where a resident was attempting to drive while intoxicated. Progress notes were reviewed and indicated that the resident was storing their alcohol in the resident activity room fridge. The care plan was reviewed and did not include a care planned focus, goals, or interventions for their alcohol consumption.

The DOC and ADOC #111 indicated that the care plan was the primary method of communication to front line staff, and should have included the residents alcohol consumption, and procedures for storage and administration.

Another complaint was received by the MLTC. The complaint involved a code white that occurred involving a resident. Clinical records were reviewed and indicated that the resident responsive behaviors on admission.

The Medical Doctor (MD) confirmed that the resident's had responsive behaviors that were exacerbated with acute changes to their health status. ADOC #111 and the DOC indicated that residents with responsive behaviors should have a care planned goal, focus and interventions. The DOC confirmed that this residents' care plan did not contain this information.

Failure to include a care planned goal, focus, and interventions for the two residents resulted in an unpleasant living environment for the residents.

Sources: Clinical record, interviews with MD, ADOC #111 and the DOC.

This order must be complied with by October 4, 2024

COMPLIANCE ORDER CO #002 Safe storage of drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

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

The DOC or designate shall educate all registered staff on the first floor of it's policy on Alcohol storage. All records to be retained and produced to inspectors upon request.

Grounds

The licensee failed to ensure that a resident's alcoholic beverages were kept in an area that was secure and locked.

Rationale and Summary:

A complaint was received by the Ministry of Long Term Care (MLTC). The complaint was related to the storage of a resident's alcoholic beverages in the resident activity room fridge.

Progress notes indicated that the registered staff stored the resident's alcoholic beverages in the activity room fridge.

The home's policy indicated that the home should have a locked area for the storage of alcohol which is restricted to designated employees.

The DOC and ADOC #111 indicated that the registered staff were supposed to store the resident's alcoholic beverages in the nursing medication room where it is kept locked and secure. The DOC indicated that the resident was known to bring in alcoholic beverages without informing the registered staff.

Failure to keep the resident's alcoholic beverages stored in the medication room where it is kept locked and secure posed a risk of harm to the residents that had access to the activity room fridge.

Sources: The homes policy, observations, interviews with ADOC #111 and DOC.

This order must be complied with by October 11, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days

from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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.