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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: December 28, 2023
Inspection Number: 2023-1115-0006
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare York, Sudbury

Lead Inspector	**Inspector Digital Signature**
Karen Hill (704609)	Karen L Hill Digitally signed by Karen L Hill Date: 2024.01.12 14:54:42 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 27-30, 2023.

The following two intakes were inspected:

- One intake related to concerns about improper/incompetent care of resident
- One intake related to an infectious disease Outbreak

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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
When reassessment, revision is required
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 the plan of care for a resident was revised when their care needs changed, related to toileting.

Rationale and Summary
A resident's care plan indicated that a specific toileting device was to be used for all toileting.

Several staff members identified that the resident's condition had changed and that they now used an alternate method for toileting.

An Assistant Director of Care (ADOC) confirmed that the information in the resident's care plan should have been updated to reflect the change.

After speaking with the Inspector, the ADOC ensured that the resident's care plan was revised to reflect their most current needs related to toileting.

There was minimal impact and low risk to the resident, at the time of the non-compliance, when the home did not ensure that the care plan was revised to reflect the resident's current toileting needs.

Sources: A resident's clinical health record; and interviews with an ADOC and other staff members.

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Date Remedy Implemented: November 29, 2023

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee has failed to ensure that the planned care intervention for a resident was included in the resident's written plan of care.

Rationale and Summary
To relieve pressure, a resident reported that staff would switch the resident's

position between two surfaces; multiple staff members confirmed that the intervention was implemented.

The intervention was not included in the resident's written plan of care.

An ADOC acknowledged that the plan of care should have been updated to include the repositioning intervention.

At the time of the noncompliance, the risk to the resident was low, as the staff were aware of the intervention of repositioning and were implementing the intervention.

Sources: Observations of resident, review of a resident's clinical health record, licensee's skin policy; and interviews with a resident, an ADOC and other staff members.

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WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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 a resident's plan of care set out clear direction to staff regarding their falls prevention needs.

Rationale and Summary
A resident was identified at risk for falls. The resident's care plan included specific falls interventions.

Observations of the resident revealed that the interventions were implemented in various ways.

One staff member indicated that the interventions were to always be in place however, another staff member stated that the interventions only applied at a specific time.

An ADOC confirmed that the resident's care plan was not clear and should have indicated when and how the interventions were to be implemented.

There was actual risk to the resident when the plan of care failed to provide clear direction to staff related to falls prevention interventions.

Sources: Observations of a resident; a resident's care plan; and interviews with an ADOC and other staff members.

[704609]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act

Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff

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

Rationale and Summary
A resident's progress notes indicated that the resident reported an allegation of staff to resident neglect.

The home was not able to provide any documentation that an investigation had occurred.

The Administrator confirmed that the home did not have an investigation file demonstrating that an investigation had taken place.

Failure to ensure that an incident of alleged neglect was immediately investigated had minimal impact on the resident however, it may have put the resident at risk of experiencing a similar situation.

Sources: A resident's clinical health record; and interviews with the Administrator and other staff members.

[704609]

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1)

Reporting certain matters to Director

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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident had occurred by a staff member, was immediately reported to the Director.

Rationale and Summary

A registered staff member reported an allegation of staff neglect to an ADOC.

An ADOC stated they were unaware if the allegation was reported to the Director.

The Administrator confirmed that the allegation was not reported to the Director.

There was minimal risk to the resident when the home did not immediately report the allegations of neglect to the Director.

Sources: A resident's clinical health record; and interviews with an ADOC, the Administrator, and other staff members.

[704609]

WRITTEN NOTIFICATION: Directives by Minister

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that the long-term care home carried out every operational or policy directive that applies to the long-term care home (LTCH), specifically related to masking requirements.

Rationale and Summary
In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, and the COVID-19 guidance document for long-term care homes in Ontario; masks were required to be worn in all resident areas indoors by all staff, students, support workers and volunteers.

Throughout the inspection, the Inspector observed two separate occasions where staff did not wear their mask as required.
The staff members and the IPAC lead identified that all staff members were required to wear their masks at all times, when in resident areas indoors.

Failure of the staff to follow enhanced masking requirements as per the Minister's Directive may have put residents at risk of transmission of infections in the home.

Sources: Observations; review of Minister's Directive: COVID-19 response measures for LTCHs ", effective August, 2022, COVID-19 guidance document for LTCHs, updated November 2, 2023, memo titled, "Enhanced Masking in LTCHs", dated November 2, 2023, issued by the Assistant Deputy Minister of LTC Operations, and internal communications; and interviews with the IPAC lead and other staff members.

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WRITTEN NOTIFICATION: Skin and wound care

NC #007 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 a member of the registered nursing staff, if clinically indicated

The licensee has failed to ensure that when a resident was exhibiting altered skin intergrity, they were reassessed at least weekly by a member of the registered staff.
Rationale and Summary
On a specified date, a resident was identified with an area of altered skin integrity.

Review of the resident's clinical health records revealed that on multiple occasions, weekly skin assessments were not completed.

Registered staff members and two ADOCs confirmed that the resident had altered skin integrity that required a weekly reassessment; that the assessments were to be documented in the resident's clinical health record, and signed off weekly, on a specific sheet designated by the home.

Failure to complete weekly skin reassessments put the resident at risk of delayed treatment and healing.

Sources: Review of a resident's clinical health record, home's wound care binder and the licensee's policy titled, Skin and Wound Program: Wound Care Management; and interviews with two ADOCs, and registered staff members.

[704609]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
The licensee has failed to ensure that a continence care product was not used as an alternative to providing assistance to a resident to toilet.

Rationale and Summary
A resident requested assistance from a staff member with toileting, but the requested assistance was not provided.

Several staff members and an ADOC acknowledged that the resident should have received the assistance that was requested from the staff member.

Failure to to provide the resident with the requested assistance put the resident at risk for compromised physical and emotional well-being.

Sources: Review of a resident's clinical health record; and interviews with an ADOC and other staff members.

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COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

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

1) Conduct weekly documented audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the resident's symptoms of infection on every shift. Audits must be continued for a minimum of four weeks, or longer if concerns are identified. A record of the audits must be maintained.

Grounds
The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored.

Rationale and Summary
1) A resident was placed in isolation and was started on an antibiotic to treat an infection.

There was no indication in the resident's clinical health record that on every shift, the resident's infection was being monitored or that symptom surveillance had occurred.

A registered staff member and the IPAC lead confirmed that symptom surveillance was required to be completed and documented in the resident's chart on every shift.

Failure to complete and document symptom surveillance every shift, put the resident at risk for discomfort and further infection.

Sources: A resident's clinical health record, IPAC Resident Infection Report for the resident, licensee's policy titled, Infection Surveillance; and interviews with a registered staff member and the IPAC lead.

Rationale and Summary
2) The LTCH reported an infectious disease outbreak to the Director.

A document in the home identified that at the onset of the outbreak, several residents were placed in isolation which required symptom surveillance.

A review of three of the affected residents' clinical health records revealed that there were multiple shifts in which there was no symptom monitoring of the residents.

A registered staff member and the IPAC lead stated that symptom surveillance for infection should have been completed and documented in the residents' clinical health record, as well as on the licensee's 24 hour symptom surveillance form for the residents, on every shift.

Failure to complete symptomatic infection monitoring of the three residents, on every shift, increased the risk of infection spreading in the home because the home was in an outbreak and the residents were diagnosed with an infectious disease at the time.

Sources: Three resident's progress notes and assessments; IPAC Resident Infection Report for one resident, licensee 24 hour Symptom Surveillance Form, home's outbreak investigation line list form, licensee's policy titled, Infection Surveillance, and IPAC Standard for LTCH, revised 2023; and interviews with a registered staff member and the IPAC lead.

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This order must be complied with by February 9, 2024

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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.