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: January 16, 2024

Inspection Number: 2023-1071-0005

Inspection Type:
Complaint

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Oshawa, Oshawa

Lead Inspector	**Inspector Digital Signature**
Carole Ma (741725)	Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2024.01.23 15:25:53 -05'00'

Additional Inspector(s)
Tiffany Forde (741746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 6, 7, 8, 11, 12, 13, 14, 18, 2023
The inspection occurred offsite on the following date(s): January 2, 2024

The following Complaint intake(s) were inspected:
· Intake: #00094874 - Complaint related to plan of care, neglect, weight gain
· Intake: #00094871 - Complaint related to abuse/neglect by staff, residents' bill of rights
· Intake: #00096059 - Complaint related to injury from unsecured mop handle
· Intake: #00100908 - Complaint related to hot temperatures inside the long-term care home (LTCH)
· Intake: #00101960 - Complaint related to bathing, infection prevention, improper staff training, management lying, residents' bill of rights
· Intake: #00103459 - Complaint related to verbal abuse from co-resident

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: HOME TO BE SAFE, SECURE ENVIRONMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure a safe and secure environment when an unsecured equipment fell and hit a resident.

Rationale and Summary
A resident complained to the Director that an equipment fell from a housekeeping cart and hit them.

The resident's clinical records indicated they reported the incident to a Physiotherapist. A Registered Nurse (RN) assessed the resident and noted altered skin integrity in the area of contact.

The Director of Care (DOC) confirmed an equipment from the housekeeping cart fell and hit the resident.

In failing to ensure the equipment was secured on the housekeeping cart in a resident home area, a resident was hit and sustained an injury.

Sources: Resident's clinical records, Interview with DOC. [741725]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Based on assessment of resident
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure a resident's plan of care was based on an assessment of the resident and on their needs and preferences.

Rationale and Summary
Resident #001 informed the Director of an altercation that had occurred around lunch time. The incident occurred between them and resident #002. In an interview at a later date, the resident #001 indicated they were still fearful of resident #002.

They also indicated they had spoken with the long-term care home's (LTCH) management team many times for the same issue and that no actions have been taken.

An Environmental Services Consultant (ESC) confirmed they heard an altercation during the incident, and a Registered Practical Nurse (RPN) confirmed they witnessed it. The RPN indicated that altercations between the two residents had happened previously and that they were not aware of any interventions to keep the two residents separated. A Personal Support Worker (PSW) indicated resident #002 historically exhibited responsive behaviours when faced with a specific situation.

Resident #001's clinical records indicated that in the evening on the day of the incident, they informed an RN of the conflict, and indicated that issues with the co-resident had been occurring for a year.

The RN confirmed there was a history of incidents between the two residents. When asked if the resident's care plan was updated, or if any assessments or referrals were made in response to the resident's concerns from the incident, the RN indicated that additional steps were not taken and that management had been aware of the long-standing issues between the two residents.

An RPN indicated that if a resident reported feeling unsafe, potential assessments and referrals could be conducted to provide an interdisciplinary approach. An Administrator indicated that if a resident felt unsafe after an incident with a co-resident, a Social Worker would be asked to speak with both residents and the management team would speak with staff on strategies to ensure similar incidents would not reoccur and to mitigate risks. The Administrator indicated these actions would be documented in the resident clinical records. A review of the resident's clinical records indicated that these actions did not occur.

Failing to ensure resident #001's plan of care was based on an assessment of their needs and preferences, in light of ongoing incidents with resident #002, left resident #001 feeling fearful and reportedly added to the feelings of mistrust.

Sources: Resident #001's clinical records, Interviews with an ESC, PSW, RPNs, RN and Administrator. [741725]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Integration of assessments, 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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other

The licensee failed to inform a Physician in the assessment of a resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
A complaint was submitted to the Director regarding concerns with a resident's increasing weight since admission to the LTCH.

In review of the resident's health records, the resident had a significant weight gain within six months of admission.

Review of the resident's progress notes indicated referrals sent to the Registered Dietitian (RD) regarding weight gain. During an interview with the RD, they stated the Physician was informed via communication log, however, no written notification was found in the communication log and no written documentation in Point Click Care (PCC).

During an interview with the Physician, they acknowledged that if they were aware of the significant weight gain, additional interventions would have been added.

Failure of the home to collaborate on addressing the resident's weight gain placed them at risk for ineffective weight management strategies.

Sources: Complaint, resident's health records, Height and Weight Monitoring Policy, Coroner's Report, and interviews with a Physician and RD. [741746]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from emotional abuse when the Behavioural Support Ontario (BSO) lead called 911 because resident did not comply with their instructions.

Under the Fixing Long-Term Care Act (FLTCA), 2021, the Ontario Regulation 246/22, section 2 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary

A resident indicated that they held onto a device as it was needed for later that evening, based on plans made with other residents. They asserted that at times, the device was locked in the medication room, preventing residents from accessing it. The BSO lead asked them to return the device as a co-resident was becoming upset at one of the settings. The resident refused to comply. The BSO lead indicated to the resident that if they did not provide the device then 911 would be called. As the resident continued to refuse, the BSO lead called 911.

The resident's clinical records confirmed that the resident refused to comply with the BSO lead's instructions and that as a result, 911 was called.

The BSO lead confirmed they had informed the resident of their intention to call 911 if the resident did not comply. They explained the call was made because they were concerned the situation could escalate with a co-resident. They acknowledged that 911 should be called for emergencies and also rated the risk level of the situation as a four out of ten. The BSO lead acknowledged that the resident had never been physically aggressive with any co-residents.

An Administrator confirmed that 911 was called. They also indicated that instead of calling 911, other interventions should have been used.

The BSO lead reflected that calling 911 may have interfered with the resident's right

to be independent. The Administrator reflected that the resident may have felt threatened or intimidated.

Calling 911 for refusing to comply with the BSO lead's instructions, resulted in the resident reportedly feeling violated.

Sources: Resident's clinical records, Interviews with BSO lead and an Administrator. [741725]

COMPLIANCE ORDER CO #001 COOLING REQUIREMENTS

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (4) (b)
s. 23 (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 246/22, s. 23 (4).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 23 (4) (b) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

1. Nursing management in conjunction with Environmental Services Manager (ESM) to revise "Heat-Related Illness prevention and mangement plan" to manage fluctuations of temperatures (indoors) specifically September to November when furnance is turned on for the winter months.

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Please submit the written plan for achieving compliance for inspection #2023-1071-0005 to Carole Ma (741725), LTC Homes Inspector, MLTC, by email to centraleastdistrict.mltc@ontario.ca by February 28, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee failed to ensure the heat related illness prevention and management plan for the home was implemented during the period when the home area was 26 degrees Celsius (C) or above at any point during the day and when the temperature in an area in the home measured by the licensee reached 26 degrees C or above, for the remainder of the day and the following day.

Rationale and Summary
The Director received a complaint regarding increased temperatures on specific dates. Family of a resident recorded temperatures over a specified period and found room and lounge temperatures over 26 degrees C.

The home's temperature monitoring system recorded temperatures during the hours of 00:00-23:00 in the lounge area between 27-28 degrees C, and in a specific resident room, temperatures were 27.5-29 degrees C for a specific number of consecutive days. The ESM confirmed these temperatures.

An Administrator confirmed the heat related illness prevention and management plan had not been initiated on these corresponding days.

The licensee failed to ensure the home's heat related illness prevention and management plan for the home was implemented placing residents at risk for heat related illnesses.

Sources: Temperature records, Preventing Heat-Related Illnesses policy, Interviews with a resident, ESM and Administrator. [741746]

This order must be complied with by February 28, 2024

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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

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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:

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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.