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
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Original Public Report

Report Issue Date: August 26, 2024

Inspection Number: 2024-1071-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Oshawa, Oshawa

INSPECTION SUMMARY

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

The following intake(s) were inspected:

- Intakes related to alleged staff to resident abuse.
- Intakes related to respiratory outbreaks.
- Intake related to a complaint regarding multiple resident care items.
- Intake related to a medication incident.
- Intakes related to resident falls with injury.
- Intake – First Follow-up – Compliance Order (CO) #001 from inspection #2024-1071-0001, related to FLTCA, 2021 - s. 28 (1) 1, Reporting certain matters to the Director, with Compliance Due Date (CDD) of June 26, 2024.
- Intake – First Follow-up – CO #002 from inspection #2024-1071-0001, related to O. Reg. 246/22 - s. 102 (2) (b), Infection Prevention and Control Program, with CDD of June 26, 2024
- Intake – First Follow-up – CO #001 from inspection #2024-1071-0002, related to FLTCA, 2021 s. 24(1), Duty to Protect, with CDD of June 28, 2024

- Intake – First Follow-up – CO #002 from inspection #2024-1071-0002, elated to FLTCA, 2021, s. 26, Complaints procedure, with CDD of July 28, 2024.
- Intake – First Follow-up – CO #003 from inspection #2024-171-0002, related to FLTCA, 2021 s. 28(1) 2, Reporting certain matters to Director, with CDD of June 28, 2024
- Intake – First Follow-up – CO #004 from inspection #2024-1071-0002, related to O. Reg 246/22 s. 97, Hazardous Substances, with CDD of June 28, 2024.
- Intake – First Follow-up – CO #005 from inspection #2024-1071-0002, related to O. Reg 246/22 s, 138 (1) (a) (ii), safe storage of drugs, with CDD of June 28, 2024
- Intake – First Follow-up – CO #006 from inspection #2024-1071-0002, related to O. Reg 246.22 s. 140(2), Administration of drugs, with CDD of June 28, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1071-0001 related to FLTCA, 2021, s. 28 (1) 1.

Order #002 from Inspection #2024-1071-0001 related to O. Reg. 246/22, s. 102 (2) (b)

Order #001 from Inspection #2024-1071-0002 related to FLTCA, 2021, s. 24 (1)

Order #002 from Inspection #2024-1071-0002 related to FLTCA, 2021, s. 26

Order #003 from Inspection #2024-1071-0002 related to FLTCA, 2021, s. 28 (1) 2.

Order #004 from Inspection #2024-1071-0002 related to O. Reg. 246/22, s. 97

Order #005 from Inspection #2024-1071-0002 related to O. Reg. 246/22, s. 138 (1) (a) (ii)

Order #006 from Inspection #2024-1071-0002 related to O. Reg. 246/22, s. 140 (2)

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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:

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.

The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by staff shall immediately report the suspicion and the information upon which it is based to the Director.

Summary and Rationale

A Critical Incident (CI) was submitted to the Director to report an allegation of abuse that resulted in a risk of harm. The resident reported the incident to Registered Nurse (RN) #110 the day before it was submitted to the Director. The resident indicated that they were woken during the night by two staff who entered their room, turned on the overhead light, and approached them to provide care. The resident informed the staff that they did not want care, however a PSW insisted and pulled off the resident's blanket. The resident indicated that the staff did provide care and that they overheard the staff laughing as they left their room. This interaction left the resident feeling nervous and bullied. The resident reported this incident to RN #110, who called Associate Director of Care (ADOC) #117 to report the allegation of abuse.

ADOC #117 confirmed that they had received the call from RN #110 about the allegation of abuse. They confirmed that they did not report the allegation of abuse to the Director upon receiving the information from RN #110.

Failing to ensure that the allegation of abuse was immediately reported increased the risk of further incidences.

Sources: CI Report, LTCH internal investigation documents, Interviews with staff.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that proper techniques were used to assist resident #007 with eating, including the safe positioning of the resident who required total assistance.

Rationale and Summary

A review of resident #007's clinical records indicated that the resident required extensive assistance during feeding, and to keep the resident upright, with the head of the bed elevated 90 degrees during feeding.

During an observation of the resident during lunch, Personal Support Worker (PSW) #107 was feeding the resident in bed with the head of the bed at around 45 degrees.

PSW #107 confirmed that the resident was not in an upright position. PSW #107 indicated that the resident did not like to be positioned in an upright position. PSW #107 acknowledged that they did not ask or try to position the resident in an upright position on that day. PSW #107 confirmed that they did not share the resident's wishes with the team to be properly reflected in the resident's care plan.

RN #112 and the Registered Dietician (RD) confirmed that resident #007 should have been positioned upright with the head of the bed at 90 degrees during feeding as per the care plan to minimize the risk of aspiration. RN #112 indicated that the resident's wishes were not communicated to the team.

Failing to ensure proper techniques were used to assist with eating, including safe positioning, for resident #007 put the resident at increased risk of choking and aspiration.

Sources: Observation, resident #007's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Dining and Snack Service

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

Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that resident #007 who required assistance with eating or drinking was served their meals when someone was available to provide the assistance required by the resident.

Rationale and Summary

A CI was submitted to the Director for an allegation of neglect of resident #007.

The CI report and resident #007's clinical record indicated that the resident was served a supper tray an hour before staff was available to assist in feeding the resident.

Resident #007's care plan indicated that the resident requires extensive assistance during feeding. PSW #108 and RN #112 confirmed that the resident required assistance during feeding and that the supper tray was served in the resident's room without any staff available to assist the resident with eating.

RN #112 and the RD confirmed that a resident who required staff to assist them with their meal should not be served until the staff member is seated and can provide the resident with the assistance they need.

Serving a meal to residents who require assistance before staff are available to assist with meals, minimizes the dining experience for the resident.

Sources: CI report, resident #007's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidences

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A CI report was first submitted to Director in relation to a respiratory outbreak.

ADOC #111 acknowledged outbreaks are to be reported to the Director immediately and confirmed the outbreak had been declared by Public Health two days prior.

Failure to immediately inform the Director on an outbreak, minimizes the potential responses required to manage significant concerns.

Sources: CI report, Interview with ADOC #111.

WRITTEN NOTIFICATION: Medication Management System

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

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that written policies and protocols developed for the medication management system to ensure the administration of all drugs used in the home was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the medication management program is complied with. Specifically, the registered staff did not comply with the licensee's Medication Management policy to complete two resident identifiers prior to administering medications to resident #003.

Rationale and Summary

A CIR was submitted to the Director regarding a medication incident involving resident #003. Resident #003 had been administered resident #005's medications, resulting in resident #003 being sent to hospital.

On the day of the medication incident, RN #112 had been pulled to an unfamiliar home area, until another nurse came in, to administer morning medications due to a nursing shortage on the floor. RN #112 saw resident #003 come out of a room, approach them, and asked for their medications. RN #112 asked the resident for their name, the resident provided their first name, and the RN administered the medications.

The home's medication management policy indicated two resident identifiers are required prior to administering medications, including: current resident picture from

the Medication Administration Record (MAR) / Treatment Administration Record (TAR), resident identification bracelet, verbal confirmation from resident who is capable of identifying their name, and a staff member who has a long-term relationship with the resident who can validate resident identification. Further, the policy indicated to administer medications following the eight rights of medication administration: right resident, right drug, right dose, right time, right route, right reason, right response, right documentation.

RN #112 confirmed they did not follow the eight rights of medication administration and had not asked the resident for their first and last name and did not use a second identifier prior to administering the medication to resident #003.

Failing to complete two identifiers prior to medication administration put resident #003's well-being at risk.

Sources: Medication Management policy, resident #003's clinical records, interview with RN #112.

WRITTEN NOTIFICATION: Administration of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure no drug was administered to resident #003 in the home unless the drug had been prescribed for the resident.

Rationale and Summary

A CI report was submitted to the Director regarding a medication incident involving resident #003. Resident #003 had been administered resident #005's medications, resulting in resident #003 being sent to hospital.

On the day of the medication incident, RN #112 had been pulled to an unfamiliar home area, until another nurse came in, to administer morning medications due to a nursing shortage on the floor. RN #112 saw resident #003 come out of a room, approach them, and asked for their medications. RN #112 asked the resident for their name, the resident provided their first name, and the RN administered the medications. Shortly after, another nurse came to the home area to take over the medication administration.

Resident #003 had a sudden decrease in their condition, at the same time resident #005 requested their medications from the nurse. Resident #003 was sent to hospital and the nurse realized the medications prescribed to resident #005 had been administered to resident #003 in error.

RN #112 and Director of Care (DOC) confirmed resident #003 had wrongfully been administered medications that were prescribed for resident #005.

Failing to administer resident #003 medications that had been prescribed for them put their well-being at risk.

Sources: Resident #003 and #005 clinical records, home's investigation, interview with staff.