Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2018	2017_673554_0026	019444-17, 023052-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 10, 15, 16 and 17, 2017

Intakes #019444-17, and #023052-17.

Summary of Intakes:
1) #019444-17 - Critical Incident Report (CIR) - alleged resident to resident abuse
2) #023052-17 - Critical Incident Report (CIR) - alleged resident to resident abuse

An area of non-compliance relating to Intake #022824-17 will be identified in this Inspection Report. Supporting information related to the area of non-compliance, specifically O. Reg. 79/10, s. 141 (1) can be found in this inspection report, as well as Inspection Report #2017_673554_0025, both of which were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Clinical Coordinator, Social Worker, RAI-Coordinator, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Members of the Behaviour Support Team, GABU Manager (Geriatric Assessment Behaviour Unit), Family, and residents.

During the course of the inspection, the inspector toured the long-term care home, observed staff to resident, and resident to resident interactions; reviewed clinical health records, licensee investigation of alleged resident to resident abuse incidents, reviewed licensee specific policies, specifically, Zero Tolerance of Resident Abuse and Neglect, and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours including, assessment, reassessments, interventions, and documentation of the resident's response to the interventions.

Resident #002 has a history which includes cognitive impairment.

Personal Support Workers (PSW) #102 and 106, Registered Practical Nurse (RPN) #105, Registered Nurse (RN) #100, and the Director of Care (DOC), all indicated, to the Inspector, that resident #002 is known to exhibit responsive behaviours.

Nursing staff, and the Director of Care indicated that the identified responsive behaviours exhibited by resident #002 are directed towards both residents and staff.
The clinical health record, for resident #002, was reviewed for a period of six months.

The written care plan (for an identified date) was reviewed, specific to resident #002's identified responsive behaviours, with specific interventions documented.

Progress notes, written by registered nursing staff, document approximately sixty entries, in which resident #002, exhibited responsive behaviours, many of which were directed towards other residents and staff. Two of the sixty incidents, resulted in the Director of Care submitting Critical Incident Reports (CIR) to the Director, both of which were related

to resident to resident abuse directed towards co-residents #005 and #006. An identified CIR, which occurred on an identified date, resulted in resident #005 sustaining injury. Documentation, in the clinical health record, indicated that planned interventions were often not effective. Documentation indicated that resident #002's responsive behaviours continued and at times escalated.

Registered Nurse #107 indicated in a progress note on an identified date that resident #002's responsive behaviours were worsening. There is no indication in the clinical health record that resident #002 was reassessed or alternative interventions implemented. RN #107 was unavailable for an interview during this inspection.

Resident #006 indicated that resident #002 would exhibited identified responsive behaviours directed toward him/her. Resident #006 indicated, that on a specific date, resident #002 exhibited identified responsive behaviours towards him/her, while standing at the end of his/her's (resident #006's) bed. Resident #006 indicated that he/she tried to ignore him, but resident #002 began exhibiting a specific responsive behaviour towards him/her. Resident #006 indicated telling staff that he/she was fearful of resident #002. Resident #006 indicated, that prior to the identified incident, resident #002 often exhibited responsive behaviours directed towards him/her. Resident #006 indicated that he/she now tries to avoid resident #002.

Resident #003 indicated, to the Inspector that resident #002 exhibited an identified responsive behaviours towards him/her. Resident #003 indicated being fearful of resident #002.

Registered Practical Nurse #105, who was a member of the BSO Team (Behaviour Supports Team) indicated that often resident #002's responsive behaviours escalated quickly. RPN indicated that once staff heard, and observed resident #002 exhibiting identified responsive behaviours, resident was beyond redirection.

Personal Support Workers, Registered Practical Nurse #105, Registered Nurse #100, and the Director of Care all indicated that despite interventions in place resident #002's exhibited responsive behaviours remained a challenge, and were difficult to manage, as such were unpredictable.

The clinical health record reviewed fails to provide support that resident #002 was reassessed or that different approaches were considered when interventions were ineffective specific to the responsive behaviours exhibited by resident #002.

Registered Practical Nurse #105, and Registered Nurse #100 indicated that there had been no requests and/or referrals for resident #002 to be seen by a community resource consultant in 2017.

On another identified date, nursing staff heard resident #003 yelling for help. Staff entered the identified area, and found resident #003 in distress. Resident #003 indicated to staff that he/she had been struck by resident #002. Staff attempted to remove resident #002 from the area. Resident #002 eventually left the area, and wandered down the hall and entered another resident's area. Resident #002 continued to exhibit identified responsive behaviours. Staff called 911 was called for assistance. Resident #002 was transferred to hospital for assessment and treatment.

The licensee failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours including, reassessments, or that different approaches were considered when interventions were ineffective specific to the responsive behaviours exhibited by resident #002, during the identified period.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place, and monitored ensuring that actions are taken to meet the needs of the resident with responsive behaviours including, assessment, reassessments, interventions, and documentation of the resident's response to the interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that contact was maintained with a resident who was on a medical absence or a psychiatric absence, or with the resident's health care provider in order to determine when the resident will be returning.

Related to Intake #022824-17:

Resident #002, has a history which includes cognitive impairment.

Registered Nurse (RN) #100, Registered Practical Nurse (RPN) #105, the Clinical Coordinator and the Director of Care (DOC), all, indicated, to the Inspector, that resident #002 has a history of exhibiting identified responsive behaviours. All interviewed, indicated that resident #002 was transferred to the hospital on an identified date, due an identified incident (CIR).

The Director of Care indicated that resident #002 was admitted to the hospital on an identified date. The Director of Care indicated that resident #002 has not yet returned to the long-term care home.

Registered Nurse #100, Registered Practical Nurse #105, Registered Practical Nurse-Behaviour Supports Lead #101, and the Clinical Coordinator all indicated that it is the practice of the LTCH to communicate with the hospital when a resident of the long-term care home is admitted, and during the resident's stay at the hospital. All interviewed indicated, that registered nursing staff working an identified shift is responsible for contacting the hospital, specifically the area where the resident is admitted, and obtaining an update on the resident's progress and expected return date.

The clinical health record, for resident #002, was reviewed for an identified period. The health care record, for resident #002 identifies that resident #002 was admitted to hospital on an identified date, and has not yet returned to the long-term care home.

There is no documentation, in resident #002's clinical health record as to communications with the hospital, since resident #002's initial transfer.

Registered Nurse #100, and the Clinical Coordinator both indicated that they are uncertain as to why there has been no contact with the hospital, regarding resident #002. Registered Practical Nurse #101 and #105 indicated that there had been no direction from the Director of Care to communicate with the hospital, with regards to the resident.

A representative from the hospital indicated, to Inspector #554, that resident #002 was admitted to an area in the hospital on an identified date. The identified hospital representative indicated that attempts have been made to contact the long-term care home, specifically the Director of Care, with regards to resident care, and resident's return to the long-term care home, but attempts have been unsuccessful, and calls had not been returned.

The Director of Care indicated, to the Inspector, that resident #002 remains at the hospital. The DOC indicated that resident #002 remains a resident of the long-term care home. DOC indicated that there is currently no plan in place for resident #002's return.

The Director of Care indicated that is has been the practice of the long-term care home to communicate with the hospital, when residents are admitted and during their stay at hospital. The Director of Care indicated that registered nursing staff had asked about contact and communication with hospital specific to resident #002, and that he/she had indicated to staff that there is no need to contact or communicate with the hospital.

The licensee failed to ensure that contact was maintained with resident #002 who was in hospital, or with the resident’s health care provider in order to determine when the resident will be returning. [s. 141. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place, and monitored ensuring that contact is maintained with a resident who was on a medical absence or a psychiatric absence, or with the resident's health care provider in order to determine when the resident will be returning, to be implemented voluntarily.

Issued on this 8th day of January, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.