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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Feb 22, 2018	2018_716554_0002	001596-18	Resident Quality Inspection

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
860 Alexander Court PETERBOROUGH ON K9J 6B4

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

KELLY BURNS (554), CRISTINA MONTOYA (461), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 23, 24, 25, 26, 29, 30, 31, and February 01-02, 2018

Resident Quality Inspection Intake #001596-18. The following intakes were inspected as part of the RQI, #029687-17, #028687-17, #024401-17, #005632-17, #020553-17, #020544-17, #018980-17, #017026-17, #016402-17, #009522-17, #008533-17, #008253-17, #000043-18 and #002691-18.

Summary of Intakes:

1) #029687-17 - Complaint - Emergency Plans;
2-5) #028687-17, #020553-17, #020544-17, and #008253-18 - Critical Incident Report (CIR) - incident that causes an injury to a resident for which the resident is taken to hospital, and which results in a significant change in resident's health status;
6) #024401-17 - Critical Incident Report - alleged tampering of a controlled substance;
7) #005632-17 - Other - potential low lighting;
8) #018980-17 - Complaint - specific to insufficient staffing and care not provided;
9) #017026-17 - Complaint - specific to insufficient staffing and care not provided;
10) #016402-17 - Complaint - specific to alleged environmental hazards and admission refusal;
11) #009522-17 - Critical Incident Report - specific to an injury of unknown origin;
12) #008533-17 - Critical Incident Report - alleged staff to resident abuse;
13) #000043-18 - Critical Incident Report - alleged resident to resident abuse;
14) #002691-18 - Complaint - insufficient staffing, and environment concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Office Manager, Support Services Manager, Clinical Coordinator, Resident Program Manager, Dietary Manager, Social Worker, Nursing Clerk, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, RAI-Coordinator and RAI-Back Up Staff, Behaviour Support Staff, Housekeeping Staff, Maintenance Staff, Physiotherapist, President of Resident Council, President of Family Council, Family and residents.

During the course of the inspection, the inspectors reviewed clinical health records, licensee investigations, training records specific to emergency procedures, falls prevention and management, and infection prevention and control, reviewed Resident Council meeting minutes, reviewed staffing plans, bathing shift report sheets, Program Evaluations related to Sufficient Staffing, and Falls Prevention; and reviewed licensee specific policies regarding, Infection Prevention and Control Program, Personal Protective Equipment, Outbreak Management, Hand Hygiene, Droplet Precautions, Contact Precautions, Emergency Response Plan and Fire Safety, Staff Responsibilities Related to Emergency Planning, Incident Management System, Code Red Fire, Falls Prevention and Management Program, Scott Fall Risk Screen for Residential Long-Term Care, Respite-Short Stay-Convalescent Care, Registered Staff Admission Checklist, Bathing, Showering and Water Temperature Monitoring, Medication Management, and Complaints.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **9 VPC(s)**
- **1 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents are bathed, at a minimum, of twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, and

more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Intakes: #017026-17 and #018980-17:

Resident Council meeting minutes were reviewed, by Inspector #461. Resident Council meeting minutes, dated October 2017, document that resident #032 voiced concern that twice weekly bathing was not being provide to residents.

Resident #032's clinical health record was reviewed, for the period of two months. The clinical health record fails to provide support that resident #032 was provided twice weekly bathing during the period reviewed, specifically documentation reviewed indicates that during the identified dates resident #032 was only provided weekly bathing.

Resident #032 was unavailable for an interview during this inspection.

Personal Support Workers (PSW) #102, #117, and #118 indicated to Inspector #554, that residents are not being bathed twice weekly due to staffing and workload issues.

The Director of Care indicated, to Inspector #554, being aware that resident's have voiced concern regarding twice weekly bathing not being provided. The Director of Care indicated changes have been made to the Personal Support Workers work schedules, as of January 2018, with the thought, that the change in the work schedules will ensure twice weekly bathing is provided as per the residents plan of care.

The Administrator indicated, to Inspector #554, awareness of issues surrounding twice weekly bathing not being provided when there is a nursing staff absence. The Administrator indicated that it is the belief that the recent changes in nursing work schedules will alleviate this, and that twice weekly bathing will be provided to residents.

2. Resident #009 indicated, to Inspector #554, that twice weekly bathing was not occurring. Resident indicated that twice weekly bathing is not completed at times due to staffing issues, and other times staff provide no explanation as to why bathing is not being provided. Resident #009 was able to provide dates when twice weekly bathing was not provided as per resident's plan of care and or bathing schedule.

The clinical health record, for resident #009, was reviewed for the period of approximately two months. The health record indicates that resident #009 will be bathed

or showered twice weekly.

The clinical health record fails to provide support that resident #009 was provided twice weekly bathing during the period reviewed, specifically documentation reviewed indicates that during identified dates resident #009 was only provided weekly bathing.

Resident #009 indicated when scheduled bathing is not provided, no alternative dates are offered.

A further review of clinical health records reviewed for residents #003, #031, and #033 provide further support that licensee failed to provide twice weekly bathing to residents, during the dates identified in 2017 and 2018.

Personal Support Workers (PSW) #102, #117, and #118 indicated to Inspector #554, that residents are not being bathed twice weekly due to staffing and workload issues. Personal Support Workers interviewed indicated that alternative dates for bathing are not offered to residents.

Registered Practical Nurse-RAI Back Up #148, and the RAI-Coordinator indicated, to Inspector #554, that resident #003, #009, #031, #032 and #033 were not provided bathing twice weekly during the period reviewed.

3. Resident #028 has a history which includes cognitive impairment. Resident #028 is dependent on staff for activities of daily living (ADL).

The clinical health record, for resident #028, specifically the written care plan (identified dates) indicates, that resident #028 will be bathed twice weekly with the assistance of two staff.

The clinical health record, for the period of two months was reviewed for resident #028. The clinical health record fails to provide support that resident #028 was provided twice weekly bathing during the period reviewed. Documentation, in the health record, further supports that during identified dates resident #028 went eight to eighteen days with being provided bathing.

Resident #028 was unable to be interviewed during this inspection.

Registered Practical Nurse (RPN) #148 indicated, to Inspector #554, that resident #028

had not been provided twice weekly bathing during the above review dates. RPN #148 indicated that resident #028 should have received twice weekly bathing.

RAI-Coordinator indicated, to Inspector #554, that resident #028 had not been provided twice weekly bathing during the dates reviewed by Inspector #554. RAI-Coordinator indicated that the bathing task for resident #028 had been incorrectly entered into the electronic flow record by registered nursing staff in March 2017. RAI-Coordinator indicated that the bathing task had been entered as weekly bathing as needed (PRN) instead of twice weekly bathing. RAI-Coordinator indicated that resident #028 should have received twice weekly bathing.

The licensee failed to ensure that residents are bathed, at a minimum, of twice a week by the method of their choice as indicated above for the identified residents.
During this inspection, the clinical health records were reviewed for six residents. The review failed to demonstrate that the six residents, identified, were provided twice weekly bathing, as per the resident's plan of care. Failure to provide bathing as indicated by the resident's plan of care affects the quality of care and service afforded the resident. The Compliance History provides support that the Licensee was previously issued non-compliance related to O. Reg. 79/10, s. 33 (1), during inspections conducted in February 2016 and again July 2016, in both inspections a Voluntary Plan of Correction (VPC) was issued.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care related to change in condition for resident #025.

Related to Intake #020544-17:

Review of the health record for resident #025 indicated prior to the resident's change in condition, the resident was independent with all activities of daily living and did not require the use of any mobility aides. Resident developed a change in condition, over a period of approximately one and a half months, the SDM was not provided an opportunity to participate until an identified date.

Interview with RPN #109, by Inspector #111, indicated resident #025 started to complain of new symptoms. The RPN indicated the resident was independent with toileting so staff

would not have observed an identified symptom. The RPN indicated the resident was having a decline in mobility as well and referred to PT to assess the resident's mobility and was provided a mobility aide. The RPN indicated the physician was aware of the resident's symptoms and outcome of diagnostic tests. The RPN indicated a referral to a specialist was made on an identified date. The RPN indicated no awareness that the SDM was notified of change in condition.

Interview with RPN #120, by Inspector #111, indicated recalling that resident #025 had new symptoms and diagnostic testing was ordered. The RPN indicated the physician ordered a specific diagnostic test, but such was not completed due to a change in resident's condition. RPN #120 indicated that resident continued to have identified symptoms post return from hospital and developed other symptoms, but such was not communicated with the SDM.

Interview with RN # 116, by Inspector #111 indicated being notified by staff on an identified date that resident #025 was having identified symptoms. The RN indicated resident #025 was not assessed, but an identified diagnostic test was obtained. The RN indicated the SDM was not notified.

Interview with Director of Care, by Inspector #111, indicated the expectation is that registered nursing staff should be notifying the SDM for any resident has a change in their condition, and when the physician orders diagnostic tests and all should be documented in the resident's progress notes. [s. 6. (5)]

2. The licensee failed to ensure when the resident was assessed and the plan of care was reviewed when the resident's care needs changed, the plan of care was revised related to change in condition for resident #025.

Related to Intake #020544-17:

Review of the health record for resident #025 indicated prior to the resident's change in condition, the resident was independent with all activities of daily living and did not require the use of any mobility aides. On identified dates resident developed a change in condition.

Review of the written plan of care indicated there was no plan related to a change in resident condition. The physician was not informed of the change in condition of resident #025 for a period of approximately two weeks. The review further failed to document that

the plan of care for resident #025 was revised to reflect this change. [s. 6. (10) (b)]

3. The licensee has failed to ensure, the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, and different approaches had been considered in the revision of the plan of care related to falls.

Related to Intake #020553-17:

A Critical Incident Report (CIR) was submitted to the Director for fall incident that caused an injury for which resident #024 was transferred to hospital and resulted in a significant change in condition. The CIR indicated on an identified date resident sustained a fall with injury. Resident #024 was transferred to hospital for treatment. Resident's condition declined. The CIR indicated the resident had a history of falls.

Review of the health care record for resident #024 indicated the resident was admitted with identified diagnoses and had a history of falls.

Review of the progress notes for resident #024, for a eight month period indicated the resident sustained mulitple falls during the identified period.

Review of the written plan of care for resident #024 (in place at time of falls) indicated the resident was a high risk for falls and identified specific interventions.
The plan of care was not revised when the interventions were not effective, as the resident continued to fall and other interventions were not considered until after multiple falls. [s. 6. (11) (b)]

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 the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care; that residents are assessed and the plan of care is reviewed and revised when the resident's care needs change; and that residents are reassessed and that the plan of care is revised when the care set out in the plan has not been effective, and different approaches had been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Emergency Plans.

Under LTCHA, s. 87 (2) - Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations.

Under O. Reg. 79/10, s. 230 (4) - The licensee shall ensure that the emergency plans deal with fire.

Under O. Reg. 79/10, s. 230 (7) - The licensee shall, (a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency.

Related to Intake #029687-17:

The licensee policy, 'Emergency Response Plan and Fire Safety Plan', and 'Code Red-Fire' both direct that an Emergency Response Plan (ERP) must be available and understood by all staff and volunteers, who must participate fully in emergency preparedness activities, training, drills and evacuation procedures.

Another of the licensee policies, 'Incident Management System Overview', directs that the Administrator, Staff Educator or designate will, ensure that monthly fire drills are conducted on each shift.

Support Services Manager indicated, to Inspector #554, that it is the expectation that fire drills are scheduled and conducted monthly on all shifts. Support Services Manager further indicated that fire drills are to be documented by registered nursing staff on the Fire Drill Evaluation Form, and that all staff sign attendance at fire drills on the Fire Alarm/Drill attendance sheet. Support Staff Manager's role includes the scheduling of fire drills, and indicated that registered nursing staff are responsible to follow the schedule, conduct and document the fire drill.

Support Services Manager provided, Inspector #554, with the 2017 Fire Drill schedule and all associated documentation of fire drills completed during this same period.

A review of the 2017 Fire Drill schedule and completed Fire Drill Evaluation form, and staff signature list fail to provide support that a fire drill was conducted monthly on each shift.

Support Services Manager confirmed that monthly fire drills were not completed monthly on each shift, during 2017.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Emergency Plans, specifically failed to ensure that the emergency plan related to fire was tested annually as directed under O. Reg. 79/10, s. 230 (7).

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Falls Prevention and Management.

Under O. Reg. 79/10, s 48 (1) - Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Under O. Reg. 79/10, s. 48 (2) - Each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

The licensee's policy, Falls Prevention and Management Program directs:

- That all residents will be screened on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall or multiple falls. See Scott Fall Risk Screen for Residential Long-Term Care, Appendix 4.
- Screen all residents for fracture risk on admission. See Fracture Risk Assessment and Prevention for LTC Resident, appendix 5.
- Flag residents at high risk for fall injury (e.g. new admission, Scott Fall Risk score >7, Fracture Risk >1) for additional monitoring, precautionary measures, and protective equipment on admission and re-assessment.
- Create an individualized plan addressing fall causes and risk factors such as history of falls, fractures, and recent hospitalization.

Related to Intake #028687-17:

Resident #023 was admitted to the long-term care home on an identified date.

Registered Nurse (RN) #108 indicated, to Inspector #554, that resident #023 last fall occurred on an identified date, and during this fall, resident sustained injury.

The clinical health record, for resident #023, was reviewed for the period of twelve days. Registered Nurse #108, and the Physiotherapist documents, in a progress note, that resident #023 has had multiple falls, and was at risk for falls.

The clinical health record reviewed fails to provide documentation to support that registered nursing staff or others completed a Scott Fall Risk Assessment and or a Fracture Risk Assessment on admission for resident #023.

Registered Practical Nurse (RPN) #131 indicated that a Scott Fall Risk Assessment and a Fracture Risk Assessment should have been completed on admission for resident #023.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Falls Prevention and Management. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, specific to Medication Management.

Under O. Reg. 79/10, s. 114 (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.

Review of the licensee's policy “Patch Disposal for Monitored Medication” indicated under procedure:

- Nurse to remove any used patches from the resident and place on "Patch Disposal Record Sheet". Document the resident name, date, and the strength of the patch. Use one patch disposal record sheet per shift. Keep the Patch Disposal Record Sheet and used patches in a zip lock bag in the double locked narcotic cabinet in the medication cart until the nurse has completed the medication pass. Document the number of patches removed from the resident in the "removed amount" column of the sheet. The nurse will sign on the nurse signature one line of the disposal record.
- There will be a reconciliation of the number of patches by a second nurse. The second nurse will verify that the number of patches placed on the patch disposal record sheet equals the number of patches wasted on the count sheet and then signs both the patch

disposal record sheet on the nurse signature two line and on the count sheet.
- Both nurses must place the patch disposal record sheet into the double locked secured surplus box. The pharmacist and designated nurse will dispose and denature the used patches at the assigned time.

Related to Intake #024401-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an unaccounted controlled substance. The CIR indicated that a day earlier, RPN #138 was changing resident #034's transdermal medication patches and noted the corners appeared to be cut off. RPN #138 was also the RPN that had put the two patches on the resident two days earlier. The CIR indicated the police and family were notified. The CIR was amended on an identified date, and indicated the investigation revealed three other medicated patches had been tampered with but did not indicate for which resident. The CIR indicated the investigation determined the home was unable to verify who was involved in tampering of the medicated patches. The CIR was completed by the DOC.

Interview with the DOC by Inspector #111 indicated the other medicated patches that had been tampered with had also involved resident #034. The DOC indicated during the investigation, it was determined the resident's medicated patches that were applied on two other dates had also been tampered with. The DOC was unable to provide disposal record sheets for the medicated patches.

Review of the physician orders and Mediation Administration Records for resident #034 for an identified period indicated the resident was prescribed an identified medication every 48 hours to be applied/removed at an identified hour. The nurse was to check for medication patch placement at beginning and end of each shift.

Review of the licensee's investigation and interview with registered nursing staff (RPN #142, #143, RN #107) indicated the nursing staff were removing the medicated patches for resident #034 and placing them on the medication patch disposal record sheet as directed. This sheet was not being signed by two registered nursing staff on the day the medicated patches were removed, until the sheet was placed in the drug destruction bin, two days later. In addition, the two medicated patches, from two identified dates, which were removed, identified that registered nursing staff had not signed the log record for destruction sheet until the next day, when they were placed in the drug destruction bin.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with, specific to Medication Management.

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, to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Emergency Plans, Falls Prevention and Management, and Medication Management, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure there is an organized program of personal support services for the home to meet the assessed needs of the residents.

Related to Intake #017026-17 and #018980-17:

Resident Council meeting minutes were reviewed, by Inspector #461. Resident Council meeting minutes, for an identified date in October 2017, document that resident #032 voiced concern that staff shortages are becoming an increasing concern in the long-term care home, and further indicated resident care as a result is being affected.

The Director of Care provided Inspector #554 with a document titled 'Staffing

Contingency Plan'. The Director of Care indicated, to Inspector #554, that this document is part of the licensee's Staffing Plan.

The Staffing Contingency Plan indicates the following, specific to Personal Support Workers (PSW):

All efforts must be made to replace staff when an absence has been reported. Call in procedure will be completed as per follows:
- Check the availability book to see if there is any part time or casual shift available.
- If unable to cover shift offer overtime by seniority on a rotational basis.
- If unable to cover entire shift then offer staff on days/evenings/nights to work a twelve hour shift.
- If unable to cover shift look at how assignment can change to accommodate the shortage.
- Consider, if one floor (resident home area) is busier than another, residents requiring two person transfer or assist, number of baths scheduled, should a PSW be brought in on the next shift to assist with providing any care that may have missed on the shift previous.

Registered Nurse (RN) #107, Personal Support Workers #102, #117, and #118, and the Nursing Clerk all confirmed, with Inspector #554, that the licensee does have a Staffing Contingency Plan. All interviewed confirmed that the procedure, described above, is to be implemented when staff cannot come to work.

Nursing Clerk provided dates, specifically six separate dates, when the licensee was short staffed, and the Staffing Contingency Plan was not followed. Nursing Clerk indicated that no additional staff were brought in for identified dates. Nursing Clerk, and the Resident Assessment Instrument-Coordinator (RAI-Coordinator) indicated that during the identified dates resident care, specifically bathing, was not completed as per residents care needs.

Personal Support Workers #102, 117, and #118 indicated, to Inspector #554, that nursing staff are not being consistently replaced when there are sick calls. Personal Support Workers interviewed indicated that the call in procedure (Staffing Contingency Plan) is not being followed. PSW's #102, #117 and #118 indicated that resident care is being affected when there is not sufficient staffing, specifically baths are not being completed, and or residents have to wait longer for assistance with care, toileting and assistance to the dining room.

Nursing Clerk indicated, that it is normally the Nursing Clerk responsibility to replace staff, but in absence of the Nursing Clerk, the Charge Registered Nurse is responsible for staff replacement, and is expected to follow the Staffing Contingency Plan when there is situations when staff cannot come to work. Nursing Clerk indicated registered nursing staff are not consistently following the Staffing Contingency Plan, and the resident home areas are being left short staffed, which affects resident care. Nursing Clerk indicated registered nursing staff may not be following the Staffing Contingency Plan due to workload, but indicated being unsure of the exact reasons.

Nursing Clerk indicated registered nursing staff did not follow the Staffing Contingency Plan, when staff were unable to come to work, on other dates, including most recently six dates in January 2018.

The licensee failed to ensure that the Staffing Contingency Plan was consistently implemented during situations when staff could not come to work, interviews with Personal Support Workers, RAI-Coordinator and the Nursing Clerk all indicated failure to follow the Staffing Contingency Plan is affecting resident care.

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 here is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

The licensee failed to ensure that the admission care plan identifies the resident and must include, at a minimum, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Related to Intake #028687-17:

Resident #023 was admitted to the long-term care home on an identified date.

Registered Nurse (RN) #108 indicated, to Inspector #554, that resident #023 was at risk for falls, indicating resident's last known fall occurred on an identified date.

The clinical health record, for resident #023, was reviewed for a twelve day period. Registered Nurse #108, and the Physiotherapist documents, in a progress note, that resident #023 has had multiple falls, and is at risk for falls.

The admission care plan reviewed for resident #023, initiated on an identified date, and revised three days later, does identify a focus for falls, but does not identify fall risk and or interventions to mitigate risk.

Registered Practical Nurse (RPN) #131 indicated, to Inspector #554, that the admission care plan should have identified the type of fall risk and should have identified interventions specific to falls prevention and management.

The licensee failed to ensure that the admission care plan for resident #023 identified, resident's fall risk and or interventions to mitigate risk.

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 the admission care plan identifies the resident and must include, at a minimum, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents have their personal items, including personal aids labelled within 48 hours of admission and when new items are acquired.

During the initial tour of the long-term care home and on another identified dates, Inspectors observed unlabelled personal items in resident rooms and in a spa room. All residents interviewed, by Inspectors, could not identify whom the personal items belonged too.

Personal Support Worker (PSW) #102, #117, and Registered Nurse (RN) #107 indicated, to Inspector #554 on January 25, and January 26, 2018 that personal items, such as toothbrushes, and brushes, are to be labelled for individual resident use.

The Clinical Coordinator indicated, to Inspector #554 on January 26, 2018, that personal items are labelled on admission, and when residents receive newly acquired items, such as toothbrushes, or brushes/combs.

The licensee failed to ensure that residents have their personal items labelled within 48 hours of admission and when new items are acquired.

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, to ensure that residents have their personal items, including personal aids labelled within 48 hours of admission and when new items are acquired, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

The licensee failed to ensure that all staff received retraining annually relating to Fire Prevention and Safety, Emergency and Evacuation Procedures.

Related to Intake #029687-17:

Support Services Manager indicated, to Inspector #554, that the Best Practice Lead-Staff Educator oversees the training and or retraining of all staff in the long-term care home.

Best Practice Lead-Staff Educator indicated, to Inspector #554, that the expectation is that all staff are to complete the annual retraining related to, Fire Prevention and Safety (Code Red-Fire), as well as Emergency and Evacuation Procedures. Best Practice Lead-Staff Educator indicated that Code Red-Fire is completed by staff on the electronic learning modules and the other emergency codes are retrained having staff read a power point presentation and signing to acknowledge such was completed.

Best Practice Lead-Staff Educator provided, Inspector #554, with documentation of the 2017 retraining records specific to Fire Prevention and Safety (Code Red-Fire), as well as Emergency Codes, and Evacuation Procedures.

The review of the 2017 annual retraining statistics, specific to Fire Prevention and Safety, Emergency and Evacuation Procedures, were reviewed, by Inspector #554, and identified that all staff did not receive annual retraining.

Best Practice Lead-Staff Educator acknowledged that all staff had not completed the annual retraining specific to Fire Prevention and Safety (Code Red-Fire), as well as Emergency and Evacuation Procedures.

The Administrator indicated, to Inspector #554, being unaware, until last week that all staff had not completed their annual retraining.

The licensee failed to ensure that all staff were provided annual retraining as specified under LTCHA, s. 76 (4).

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 all staff received retraining annually relating to Fire Prevention and Safety, Emergency and Evacuation Procedures, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service

provider.

Medication incidents were reviewed, for an identified three month period. Medications incidents identified as occurring during this review, and such incidents involved residents, specifically residents #044, #045, #051, 052, #053 and #054.

Medication incidents reviewed, as well as the clinical health record for identified residents, and staff interviews failed to provide support that in all incidences that there was documented evidence of immediate actions taken to assess the resident's health, nor was there documented evidence that medication incidents were reported to the resident, resident's SDM, the physician and the Medical Director.

Interview with the Director of Care (DOC), by Inspector #111, indicated the expectation is that nursing staff who discover a medication incident are to assess the resident, notify the Physician/Medical Director and the family. The DOC indicated the nurse is to document on the residents progress notes and complete the medication incident report electronically when the incident is discovered. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

Interview with the DOC, by Inspector #111, indicated all medication incident reports submitted electronically on the electronic system go directly to the pharmacy and the DOC. The DOC indicated each medication incident is reviewed with the nurse involved when received, by the DOC, and that this reviewed includes an informal meeting with the identified nurse to discuss how the incident occurred and how to prevent a recurrence, DOC indicated there is no written record of this. The DOC indicated the last PAC meeting occurred December 2017, and the medication incidents from identified period were discussed.

Review of the medication incidents, for the above identified period, a review of the health records for the identified residents (#034, #044, #045, #046, #048, #050, #051, #052, #053, #054, #055, and #056) and interview with staff indicated there was no documented evidence this occurred or any other actions taken to prevent a recurrence.

Interview with the DOC, by Inspector #111, indicated the expectation is that nursing staff

who discover a medication incident are to assess the resident, notify the Physician/Medical Director and the family. The DOC indicated the nurse is to document on the residents progress notes and complete the medication incident report electronically when the incident is discovered. The DOC indicated each medication incident is reviewed with the nurse involved. The DOC indicated that an informal meeting with the nurse involved occurs to discuss how the incident occurred and how to prevent a recurrence, but does not document this. [s. 135. (2)]

3. The licensee has failed to ensure that, (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

Interview with the DOC indicated all medication incident reports are reviewed quarterly at the Professional Advisory Committee (PAC) meetings which include the Medical Director, DOC, and pharmacy service provider. The DOC indicated the last PAC meeting occurred in December 2017. Interview with DOC indicated the PAC meeting in December 2017 reviewed the medication incidents for the identified three month period. The DOC indicated there is a discussion regarding the medication incidents with the PAC team but no written record is kept of any changes or improvements that are identified and implemented.

Review of the PAC meeting minutes, for December 2017, indicated the Medical Director, the DOC and the pharmacy consultant were in attendance. The minutes indicated under medication management, medication errors were reviewed. The minutes did not indicate which period the medication incidents were reviewed for or any changes or improvements that were identified and implemented. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; to ensure all medication incidents and adverse drug reactions are documented, reviewed and analyzed
and that corrective action is taken as necessary, and there is a written record is kept of everything required; and
a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything provided, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

Housekeeper (HSK) #100 was observed on January 23, 2017, by Inspector #111, was noted going into an identified resident room to clean the room and was seen wearing gloves. The HSK #100 was then observed exiting the identified resident room, and

proceeded to enter a second resident room with the same gloves in place. Both identified resident rooms have an identified precautions posted on the doors.

Interview with Personal Support Worker (PSW) #102, by Inspector #111, indicated residents in the identified rooms were on identified precautions.

Observation of PSW #102, by Inspector #111 providing nourishment with co-worker. The co-worker was observed completing good hand hygiene upon exiting each resident room. PSW #102 was observed entering 4 different resident rooms without performing any hand hygiene upon entering or exiting the rooms.

The Clinical Coordinator, who is the Lead for Infection Prevention and Control indicated, to Inspector #554, that the licensee follows PIDAC best practice documents, specifically 'Four Moments of Hand Hygiene". Clinical Coordinator indicated staff are expected to clean their hands using alcohol based hand rub (ABHR) and or soap and water, between residents. Clinical Coordinator indicated gloves are not to be worn in the hallways, and staff are expected to remove gloves between contact with residents and or when going from one resident environment to another. Clinical Coordinator indicated all staff have been provided training in Infection Prevention and Control, specifically hand hygiene and use of personal protective equipment.

2. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

The licensee’s policy, ‘Personal Protective Equipment’ directs that staff uses personal protective equipment supplied by the home properly and appropriately to provide care to residents. The policy indicates that all persons will comply with the use of personal protective equipment if it has been determined to be necessary by the home and or the Public Health Authority.

On January 23, 2018, during the initiation of this inspection signage was observed by Inspector #554 to be on the main entrance of the long-term care home, indicating that the home was experiencing a outbreak, the causative organism was identified.

The Director of Care, and the Clinical Coordinator indicated, to Inspector #554, that the Public Health Unit had declared the long-term care home to be in a respiratory outbreak as of an identified date. The Clinical Coordinator indicated that specific precautions were in place. The Clinical Coordinator indicated that any resident in isolation, had signage on

their doorway indicating the type of precaution in place, and the type of personal protective equipment to be worn by staff or others entering the resident's room.

Identified precautions signage on resident doors, of those affected, indicated the following:
- Personal Protective Equipment (PPE) to be worn – gown, gloves, mask and goggles to be worn within two metres of the resident.

On January 29, 2018, Inspector #554 observed the following:

- Identified Resident Room – Resident #038 was identified as being in isolation, as per the outbreak management line list, and as indicated in resident #038's clinical health record. Signage on the doorway of resident's room indicated that identified precautions were in place. Registered Practical Nurse (RPN) #125 was observed entering resident's room without donning PPE. Resident #038 was in the room.
- Identified Resident Room – Resident #037 was identified as being in isolation, as per the outbreak management line list, and as indicated in resident #037's clinical health record. Signage on the doorway of resident's room indicated that identified precautions were in place. Registered Practical Nurse (RPN) #125 was observed entering resident's room, without donning PPE. Registered Practical Nurse #125 administered an inhalation medication to this resident.
- Identified Resident Room – Resident #004 and #040 were was identified as being in isolation, as per the outbreak management line list, and as indicated in resident #004 and #040's clinical health record. No outbreak management signage and or precautions to be taken were observed on the doorway of the identified resident room. Personal Support Workers #117 and #118 confirmed that residents #004 and #040 were in an identified isolation. Registered Practical Nurse #105 was observed entering resident's room, without donning PPE, and providing medication to one of the resident's.
- Identified Resident Room - Resident #042 were was identified as being in isolation, as per the outbreak management line list, and as indicated in resident #042's clinical health record. No outbreak management signage and or precautions to be taken were observed on the doorway of the identified resident room. Personal Support Workers #126 and #127 confirmed that residents #004 and #040 were in an identified isolation.

Upon further observations, goggles as a preventative PPE were not available for staff entering and/or providing care to resident #004, #037, #038, #040 and #042.

Personal Support Workers #117, #118, #126, #127, and Registered Practical Nurse #125

indicated, to Inspector #554, that they had not been instructed to wear goggles when entering or caring for those residents identified as being in the identified isolation.

The Best Practice-Staff Education Lead, and the Clinical Coordinator indicated, to Inspector #554, that all staff have been provided training related to Infection Prevention and Control, specifically use of PPE's, and outbreak management. Best Practice-Staff Education Lead provided 2017 training records for PSW's #117, #118, #126, #127, and RPN's #105 and #125. The review indicated that the identified staff had been provided training related to Infection Prevention and Control, including use of PPE's.

The Clinical Coordinator indicated that all staff are expected to wear PPE's as identified by signage on resident's room.

Personal Support Workers #117, #118, #126, #127 and RPN #105 and #125 failed to ensure that they participate in the implementation of the infection prevention and control program.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

The licensee failed to ensure that they tested the emergency plans related to fire on an annual basis, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

Related to Intake #029687-17:

Support Services Manager indicated that the annual emergency plan, Code Red-Fire was last tested December 2016.

Support Services Manager indicated, to Inspector #554, that the licensee was issued an order by the Chief Fire Official, as they (the licensee) were to have contacted local Fire Services to arrange for annual testing of the emergency plan, specifically Code Red-Fire, during identified dates, and the license had not made arrangements for the identified annual testing.

The licensee failed to ensure that the emergency plan, related to fire, was tested on an annual basis, and included arrangements with community agencies, partner facilities and resources that would be involved in responding to an emergency.

As of January 18, 2018, the emergency plan, specific to Code Red-Fire was tested, and included local Fire Services.

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 plan in place and monitored, ensuring the emergency plans related to fire are tested on an annual basis, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

The licensee failed to ensure that when the licensee withholds approval for admission, the licensee gives the persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval, (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements of care.

Under LTCHA, 2007, the grounds for withholding approval are identified under s. 44 (7), the appropriate placement co-ordinator shall give the licensee copies of assessments and information that would be required to have been taken into account, under subsection 43 (6); the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

On an identified date, the Community Care Access Centre (CCAC) submitted a referral for an identified application to the Director of Care (DOC), for applicant #030. The CCAC application indicated the applicant required a specific routine. The application included two letters, one from a physician and one from a Nurse Practitioner (NP).

On an identified date, Applicant #030 received a written notice from the DOC withholding approval for admission. The notice indicated the ground for refusing the application was due to the home not having the staffing resources in the facility. The detailed explanation

indicated the applicant required a specific routine throughout the day at specific times.

Interview with Administrator, by Inspector #111, indicated the DOC and the Best Practice Coordinator (BPC) are responsible for reviewing applications for admission.
Interview with the Best Practice Coordinator, by Inspector #111, indicated usually the DOC and/or the BPC review the applications for admissions. The BPC indicated the DOC provides the refusal letters to applicants.

Interview with the DOC, by Inspector #111, indicated the home could not offer an identified admission to the applicant as the applicant required a specific routine and the nursing staff did not have time to provide this.

Interview with RN #107, by Inspector #111, indicated the home currently has residents who a similar routine and they are given such according to the physician's orders.

The licensee refused an application for an identified admission based on lack of staff resources to provide a specific routine. This does not meet the criteria of nursing lacking the expertise.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant, a description of the response, and any response made by the complainant.

Related to Intake # 002691-18:

Resident #058 indicated, to Inspector #554, that there is concerns regarding air circulation. Resident #058 indicated concerns were voiced to nursing staff, and maintenance staff. Resident #058 indicated requesting to speak with the Director of Care, but as of this time, the Director of Care has not came up to address concerns, specific to air circulation.

The clinical health record, for resident #058, documents that resident has voiced concerns to nursing staff, including registered nursing staff, and the physician over a period of approximately one week.

Registered Practical Nurse (RPN) #104 indicated that resident #058 has been voicing concerns regarding the air circulation for approximately two weeks. RPN #104 indicated that the Charge Nurses, and management are aware of resident #058's concerns.

The Administrator indicated, to Inspector #554, being unaware of resident #058's concerns. The Administrator indicated that all concerns/complaints are to be documented on the 'Complaint Investigation Form' and to be submitted to the manager or supervisor responsible for the specific department, and submitted also to the Administrator for review and follow up.

Support Services Manager indicated, to Inspector #554, that the management team, including the Director of Care and the Administrator are aware of resident #058's complaint, and have been discussing the concern in morning report over the past week. Support Services Manager indicated at this time, there has been no resolution.
The Administrator indicated that there is no documentation on file, other than notations made in the resident #058's health record.

The licensee failed to ensure that resident #058’s concern/complaint was documented and kept in the home including, the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant, a description of the response, and any response made by the complainant.

Issued on this 28th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554), CRISTINA MONTOYA (461), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2018_716554_0002
Log No. / No de registre :	001596-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Peterborough 860 Alexander Court, PETERBOROUGH, ON, K9J-6B4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Thurlow

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall prepare, implement and submit a plan of corrective action to include the following:

The licensee will immediately ensure all residents are provided a minimum of twice weekly bathing, by a method of his or her choice, unless contraindicated by a medical condition.

In addition, the licensee shall:

- Revise the procedure for monitoring that daily scheduled bathing is completed by Personal Support Workers. Ensure that the daily scheduled bathing is being monitored by a designated supervisor, and the Director of Care to ensure that residents are being provided a minimum of twice weekly bathing, as per the resident's plan of care.
- When daily scheduled bathing has not been provided, revise the 'Bath Shift Report' procedure to ensure that such clearly indicates why the bath was not provided, and clearly indicates when an alternate bathing time, including date and time will be provided within that same week period.
- When a resident refuses bathing, ensure the reason for the refusal is indicated, where and how that is documented, and/or alternatives offered.
- Ensure nursing staff are retrained on the revised procedures specific to resident bathing requirements, and the documentation practices related to the same, to ensure residents are provided a minimum of twice weekly bathing as per the resident's plan of care.

The plan will include who will be responsible for each task and completion dates.

The plan must be submitted in writing to the Central East Service Area Office (CE SAO) and faxed to (905) 433-3008 on or before March 05, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that residents are bathed, at a minimum, of twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Intakes: #017026-17 and #018980-17:

Resident Council meeting minutes were reviewed, by Inspector #461. Resident Council meeting minutes, dated October 2017, document that resident #032 voiced concern that twice weekly bathing was not being provide to residents.

Resident #032's clinical health record was reviewed, for the period of two months. The clinical health record fails to provide support that resident #032 was provided twice weekly bathing during the period reviewed, specifically documentation reviewed indicates that during the identified dates resident #032 was only provided weekly bathing.

Resident #032 was unavailable for an interview during this inspection.

Personal Support Workers (PSW) #102, #117, and #118 indicated to Inspector #554, that residents are not being bathed twice weekly due to staffing and workload issues.

The Director of Care indicated, to Inspector #554, being aware that resident's have voiced concern regarding twice weekly bathing not being provided. The Director of Care indicated changes have been made to the Personal Support Workers work schedules, as of January 2018, with the thought, that the change in the work schedules will ensure twice weekly bathing is provided as per the residents plan of care.

The Administrator indicated, to Inspector #554, awareness of issues surrounding twice weekly bathing not being provided when there is a nursing staff absence. The Administrator indicated that it is the belief that the recent changes in nursing work schedules will alleviate this, and that twice weekly bathing will be provided to residents.

2. Resident #009 indicated, to Inspector #554, that twice weekly bathing was not occurring. Resident indicated that twice weekly bathing is not completed at times due to staffing issues, and other times staff provide no explanation as to why bathing is not being provided. Resident #009 was able to provide dates when twice weekly bathing was not provided as per resident's plan of care and or bathing schedule.

The clinical health record, for resident #009, was reviewed for the period of approximately two months. The health record indicates that resident #009 will be bathed or showered twice weekly.

The clinical health record fails to provide support that resident #009 was provided twice weekly bathing during the period reviewed, specifically documentation reviewed indicates that during identified dates resident #009 was only provided weekly bathing.

Resident #009 indicated when scheduled bathing is not provided, no alternative dates are offered.

A further review of clinical health records reviewed for residents #003, #031, and #033 provide further support that licensee failed to provide twice weekly bathing to residents, during the dates identified in 2017 and 2018.

Personal Support Workers (PSW) #102, #117, and #118 indicated to Inspector #554, that residents are not being bathed twice weekly due to staffing and workload issues. Personal Support Workers interviewed indicated that alternative dates for bathing are not offered to residents.

Registered Practical Nurse-RAI Back Up #148, and the RAI-Coordinator indicated, to Inspector #554, that resident #003, #009, #031, #032 and #033 were not provided bathing twice weekly during the period reviewed.

3. Resident #028 has a history which includes cognitive impairment. Resident #028 is dependent on staff for activities of daily living (ADL).

The clinical health record, for resident #028, specifically the written care plan (identified dates) indicates, that resident #028 will be bathed twice weekly with the assistance of two staff.

The clinical health record, for the period of two months was reviewed for resident #028. The clinical health record fails to provide support that resident #028 was provided twice weekly bathing during the period reviewed. Documentation, in the health record, further supports that during identified dates resident #028 went eight to eighteen days with being provided bathing.

Resident #028 was unable to be interviewed during this inspection.

Registered Practical Nurse (RPN) #148 indicated, to Inspector #554, that resident #028 had not been provided twice weekly bathing during the above

review dates. RPN #148 indicated that resident #028 should have received twice weekly bathing.

RAI-Coordinator indicated, to Inspector #554, that resident #028 had not been provided twice weekly bathing during the dates reviewed by Inspector #554. RAI-Coordinator indicated that the bathing task for resident #028 had been incorrectly entered into the electronic flow record by registered nursing staff in March 2017. RAI-Coordinator indicated that the bathing task had been entered as weekly bathing as needed (PRN) instead of twice weekly bathing. RAI-Coordinator indicated that resident #028 should have received twice weekly bathing.

The licensee failed to ensure that residents are bathed, at a minimum, of twice a week by the method of their choice as indicated above for the identified residents.

During this inspection, the clinical health records were reviewed for six residents. The review failed to demonstrate that the six residents, identified, were provided twice weekly bathing, as per the resident's plan of care. Failure to provide bathing as indicated by the resident's plan of care affects the quality of care and service afforded the resident. The Compliance History provides support that the Licensee was previously issued non-compliance related to O. Reg. 79/10, s. 33 (1), during inspections conducted in February 2016 and again July 2016, in both inspections a Voluntary Plan of Correction (VPC) was issued. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Kelly Burns

Service Area Office / Bureau régional de services : Ottawa Service Area Office