

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

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 20, 2021	2021_861194_0013	005484-21, 012112-21	Critical Incident System

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**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.  
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Peterborough  
860 Alexander Court Peterborough ON K9J 6B4

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

CHANTAL LAFRENIERE (194)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): September 23, 24, 27, 28, 29 and October 5, 2021**

**Inspected Log #005484-21 for resident to resident abuse,  
Log #012112-21 for a resident fall**

**During the course of the inspection, the inspector(s) spoke with Resident, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse and Personal Support Worker (PSW).**

**During the course of the inspection the inspector reviewed the clinical health record of the identified residents, Falls Management Program, Zero Tolerance of resident Abuse and Neglect Program. The inspector observed the staff to resident provision of care and resident mobility.**

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

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

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

## Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee's Fall Management Program included a Head Injury Routine (HIR) to be completed for residents for all unwitnessed falls, hourly for four hours and every shift for 72 hours.

Resident #002 had a specified number of unwitnessed falls. Review of the clinical health record confirmed that the HIRs were not completed. RN #132 confirmed that on an identified date, HIR for the resident should have been initiated and it was not. RPN #129 confirmed that the initial set of vital signs were obtained and the remaining HIR was not completed as required. On another identified date, HIRs were not completed. On another date, HIR were obtained at the time of the fall but not completed as required. Failing to complete HIR, places the resident at increased risk for potential complications related to head injury.

Sources: Clinical health records for resident #002 and staff interviews. [s. 49. (2)]

## ***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 by ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

**Issued on this 22nd day of October, 2021**

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

**Original report signed by the inspector.**