Ontario

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

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Central East District**
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# Amended Public Report Cover Sheet (A1)

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| **Amended Report Issue Date: August 30, 2023** | |
| **Original Report Issue Date:** August 9, 2023 | |
| **Inspection Number:** 2023-1088-0001 (A1) | |
| **Inspection Type:**<br>Complaint | |
| **Licensee:** Extendicare (Canada) Inc. | |
| **Long Term Care Home and City:** Extendicare Peterborough,Peterborough | |
| **Amended By**<br>Kelly Burns (000722) | **Inspector who Amended Digital Signature** |

## AMENDED INSPECTION SUMMARY

This report has been amended to:

This report was amended at the request of the licensee to amend the verbiage in Compliance Order #005 to include 'supervisor(s)'. The 'supervisor', as defined in the discussion with the licensee MUST be 'registered staff'. Additionally, the registered staff designate MUST receive training on how to properly conduct the audit prior to commencing and records of the training details must be documented and kept.

Additionally, Compliance Order #002 was amended, at the request of the licensee, to include verbiage surrounding what the licensee or designate is to document in, resident #003's, clinical health record should the resident be absent from the home (e.g., leave of absence) and registered nursing staff be unable to complete the ordered pain assessment.

The licensee was to proceed with the amendments, as discussed and specific, to Compliance Orders #002 and #005 as of Tuesday August 22, 2023.

# Amended Public Report (A1)

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| **Lead Inspector**<br>Kelly Burns (000722) | **Additional Inspector(s)** |
| **Amended By**<br>Kelly Burns (000722) | **Inspector who Amended Digital Signature** |

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This report was amended at the request of the licensee to amend the verbiage in Compliance Order #005 to include 'supervisor(s)'. The 'supervisor', as defined in the discussion with the licensee MUST be 'registered staff'. Additionally, the registered staff designate MUST receive training on how to properly conduct the audit prior to commencing and records of the training details must be documented and kept.

Additionally, Compliance Order #002 was amended, at the request of the licensee, to include verbiage surrounding what the licensee or designate is to document in, resident #003's, clinical health record should the resident be absent from the home (e.g., leave of absence) and registered nursing staff be unable to complete the ordered pain assessment.

The licensee was to proceed with the amendments, as discussed and specific, to Compliance Orders #002 and #005 as of Tuesday August 22, 2023.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 17-18, 23-26, 29-31, 2023; and June 1-2, 2023

The following intake(s) were inspected:
Intake: #00003587, #00015744 and #00087826 – Complaints regarding care and operations of the long-term care home.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices
Pain Management
Falls Prevention and Management
Resident Charges and Trust Accounts

# AMENDED INSPECTION RESULTS

## WRITTEN NOTIFICATION: Right to be treated with respect

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

The licensee failed to ensure that the following rights of residents were fully respected and promoted, specifically the right to have their lifestyle and choices respected.

**Rationale and Summary:**

A multifaceted compliant was received by the Director, one of the concerns was related to a resident not being permitted to engage in certain lifestyle choice while residing at the long-term care home.

On admission to the long-term care home, resident #003 and their family were told by staff that resident could engage in a specific lifestyle choice in the parking lot and told resident's supplies could be stored with registered nursing staff. Resident and their family indicated while outdoors in the parking lot, a manager of the home approached and told them that the home was smoke-free and could engage in their lifestyle choice off the property. Resident's family indicated they were called twenty-four to forty-eight hours later and told by a manager that resident's lifestyle supplies could not be stored at the LTCH, due to the home being a smoke-free facility. Resident and their family voiced frustration, indicating this is supposed to be the resident's home.

Throughout this inspection, staff of the home were observed smoking on the property.

Senior Director of Care (SR DOC) indicated the LTCH is a smoke-free facility and confirmed the policy did not apply to staff.

Failure of the licensee to respect resident lifestyle and choices violates the Residents' Bill of Rights and creates an environment unconducive to home for a resident.

**Sources:** Observations during the inspection; interviews with a resident, resident's family, staff, and managers. [000722]

## WRITTEN NOTIFICATION: Based on assessment of the resident

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee failed to ensure that the care set out in the plan of care was based on the assessed needs and preferences of a resident.

**Rationale and Summary:**

A multifaceted complaint was received by the Director, one of the concerns was related to staff not applying resident's immobilization device.

Resident #003 was assessed and required an immobilization device to be applied daily. Resident indicated the immobilization device had not been applied since their admission. Resident indicated staff had commented they did not know how to apply the immobilization device.

The Physiotherapist (PT) indicated being aware the resident required the immobilization device to be worn. The PT confirmed that they, their assistant nor staff were applying the immobilization device. The PT further confirmed there had been no training provided, to staff, regarding the application of the resident's immobilization device.

Failure of staff to apply resident's immobilization device, placed the resident at risk for mobility issues.

**Sources:** Observations of a resident; review of the clinical health record; interviews with resident, PT and staff. [000722]

## WRITTEN NOTIFICATION: Integration of assessments, care

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee failed to ensure that staff and others involved with the care of a resident collaborate with each other.

**Rationale and Summary:**

A multifaceted complaint was received by the Director, one of the concerns was related to the delayed initiation of a wellness program.

Resident #003 was admitted to the home and was known to engage in a specific lifestyle choice.

The Director of Care-Quality (DOC-Quality) and the Senior Director of Care (SR DOC) indicated the resident had been non-compliant with a licensee policy. SR DOC indicated that resident had been placed on enhanced staff monitoring due to resident's non-compliance with the licensee's policy.

Documentation in the clinical health record, written by the Admission Coordinator, indicated resident #003 was advised that the home was a 'smoke-free' home and indicated the resident had agreed to participate in a specific wellness program. Documentation identified nine days following resident's

admission to the home, resident was provided information regarding the program. Twenty-nine days following resident's admission, documentation, by the Director of Care (DOC), indicated there had been no physician orders obtained for the initiation of the program. The physician for the resident was contacted and orders were obtained for medication. The order was initiated seven days later.

Failure of the registered nursing staff, nursing management and the physician to collaborate in a resident's planned care, contributed to the 'believed' responsive behaviours exhibited by a resident, and in turn negatively affected resident well-being.

**Sources:** Review of the clinical health record for a resident; interview with a resident, resident's family, staff and management. [000722]

## WRITTEN NOTIFICATION: Consent

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 7

The licensee failed to obtain a resident's consent prior to implementing enhanced staff monitoring.

**Rationale and Summary:**

A multifaceted complaint was received by the Director, one of the concerns related to a resident being placed on enhanced staffing without their consent.

Resident #003 and their family indicated an individual was placed outside resident's room twenty-four hours a day without their consent. Resident indicated the individual followed them around the home, including into other resident's rooms. Resident and their family indicated they had not consented to the enhanced staffing. Resident emotionally indicated they felt as if they were living in jail.

Resident's health care record was reviewed. Documentation indicated the enhanced staff monitoring was implemented, as directed by the Senior Director of Care (SR DOC). The enhanced staff monitoring continued for approximately three weeks, at which time it was discontinued and safety checks were implemented for a period of two weeks. Documentation reviewed failed to provide evidence the resident, who is their own decision maker, had consented to the enhanced staff monitoring.

The Director of Care-Quality (DOC-Quality) indicated an impromptu meeting was held with the resident, discussions included behaviours alleged to be exhibited by the resident. DOC-Quality indicated resident

denied all allegations, became frustrated and excused themselves from the meeting. DOC-Quality confirmed that enhanced staff monitoring was implemented following the meeting and indicated there had been no consent obtained from resident.

SR DOC confirmed that enhanced staff monitoring had been implemented at their direction. DOC-Quality and the SR DOC indicated there had been no documentation of unsafe behaviours occurring and indicated alternative strategies had not been discussed with the resident prior to the enhanced staff monitoring beginning.

Failure to assess and implement care or services without the consent of the resident or the resident's Substitute Decision Maker (SDM) threatens relationships between the resident and the home, demonstrates disrespect of the resident involving their care and poses a power imbalance perceived by residents and their SDMs.

**Sources:** Observations the enhanced staff monitoring; review of a resident's clinical health record; interviews with a resident, resident's family, staff and management. [000722]

## WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

The licensee has failed to ensure that the home was kept clean and sanitary.

**Rationale and Summary:**

Throughout the inspection, a pungent odour was detected on a resident unit. A Personal Support Worker (PSW) indicated that the odour was most likely coming from the washroom in one resident's room.

The washroom flooring, in a identified resident's room, was observed to be heavily soiled. The tiled flooring, in the washroom, was observed to have dark brown staining in front of and extending around the toilet, under the sink, along the flooring threshold of the washroom and into the shared resident bedroom. The flooring was visibly wet in front of and around the toilet, and under the sink. An unknown fluid was observed seeping from underneath the flooring tiles, in front of the toilet and under the sink, as the Inspector walked into the washroom.

Staff indicated that the fluid seeping from beneath the tiled flooring in the resident's washroom was 'urine'. Staff indicated the washroom flooring had been in an unsanitary state for well over a year; all indicated the Environmental Services Manager (ESM), and the former Executive Director were aware of the state of the flooring in resident washroom.

The ESM confirmed being aware of the flooring concerns in resident washroom, and indicated it was their belief that a resident's behaviour was contributing to the unsanitary condition of the washroom. ESM indicated they had not communicated this belief to the Nursing department for their follow-up, as 'they should already know'.

Operations Manager indicated the state of the resident washroom was unacceptable.

Failure to keep resident washrooms clean and sanitary places residents at risk for infections and is not conducive to a home-like atmosphere.

**Sources:** Observations of a washroom in a resident's room; interviews with staff and management. [000722]

## WRITTEN NOTIFICATION: Licensee must investigate, respond and act

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

1.The licensee failed to ensure that an allegation of staff to resident abuse was immediately investigated.

**Rationale and Summary:**

A complaint was received by the Director where a Substitute Decision Maker (SDM) indicated that resident #002 had complained staff at the long-term care home (LTCH) had abused them. SDM indicated reporting the allegation of abuse to registered nursing staff and managers.

The clinical health record was reviewed and identified a Registered Practical Nurse (RPN) documented that a SDM had alleged that staff had been abusive to the resident. The clinical health record identified, the RPN had notified a Registered Nurse (RN) and the Director of Care (DOC) as to the allegations of staff to resident abuse.

Director of Care-Quality indicated being aware of the staff to resident abuse allegation. DOC-Quality indicated the former DOC would have been responsible for investigating the alleged abuse. DOC-Quality and the Senior DOC indicated there was no documentation that the alleged abuse was investigated.

Failure of the licensee to investigate an allegation of staff to resident abuse placed the resident and other residents at risk of harm.

**Sources:** Review of the clinical record for a resident; interviews with resident's SDM, and management. [000722]

2.The licensee failed to ensure that an allegation of staff to resident abuse was immediately investigated.

**Rationale and Summary:**

A complaint was received by the Director which indicated that resident #002 reported to a Registered Practical Nurse (RPN) they were being abused by staff. Later that same day, an RPN documented the resident had complained that a couple had entered their room and abused them; resident described the individuals to the RPN. Documentation identified the resident continued to voice fear to staff about an unknown person entering their room.

The Director of Care-Quality indicated that there had been no investigation of the alleged abuse incident, and indicated an investigation should have taken place.

Failure of the licensee to investigate an allegation of resident abuse placed the resident and other residents at risk of harm.

**Sources:** Review of the clinical record for a resident; internal training records related to abuse investigations for an RPN and nursing managers; interviews with resident's SDM, and management. [000722]

## WRITTEN NOTIFICATION: Reporting certain matters to Director

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

1.The licensee failed to ensure the Director was immediately notified of an alleged abuse of a resident.

Pursuant to O. Reg. 246/22, s. 2 (1) for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

**Rationale and Summary:**

A complaint was received by the Director indicating that a Substitute Decision Maker (SDM) indicated that resident #002 had complained to them that staff at the long-term care home had allegedly abused them. SDM indicated reporting the allegation to registered nursing staff and managers.

The clinical health record was reviewed and identified a Registered Practical Nurse (RPN) documented that SDM had alleged that staff had abused the resident. The clinical health record identified the RPN notified a Registered Nurse (RN) and the Director of Care (DOC) as to the abuse allegations.

Director of Care-Quality (DOC-Quality) indicated being aware of the abuse allegation. DOC-Quality indicated the DOC would have been responsible for notifying the Director of the alleged resident abuse. DOC-Quality confirmed the alleged abuse incident had not been reported to the Director. The Senior DOC, for Extendicare, indicated the allegation should have been submitted to the Director.

Failure of the licensee to immediately report alleged, suspected or witnessed abuse placed a resident and others at risk of harm.

**Sources:** Review of the clinical record for a resident; interviews with resident's family, and management. [000722]

2.The licensee failed to ensure the Director was immediately notified of alleged abuse of a resident by staff.

**Rationale and Summary:**

Resident #002 reported to a Registered Practical Nurse (RPN) that they were being abused by staff. Later that day, an RPN documented resident had complained that individuals entered their room and allegedly abused them; resident described the individuals to the RPN. Documentation the next day, identified the resident continued to voice fear about an individual entering their room.

DOC-Quality indicated that the Director had not been notified of the alleged abuse of the resident by staff or others. DOC-Quality and the Senior DOC confirmed that the allegation of abuse should have

been reported to the Director.

Failure of the licensee to immediately report alleged, suspected or witnessed abuse placed the resident and others at risk of harm.

**Sources:** Review of the clinical record for a resident; training records for an RPN and the DOC-Quality; interviews with resident's SDM, and management. [000722]

## WRITTEN NOTIFICATION: Policies and Records

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

The licensee failed to ensure their Falls Prevention and Management Program, a required program under, O. Reg. 246/22, s. 53 (1) 1 was complied with, specifically related to the monitoring of residents who had fallen.

Pursuant to, O. Reg. 246/22, s. 54 (1), The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

**Rationale and Summary:**

The licensee's policy, Falls Prevention and Management Program directs, that if a resident falls and hits their head or is suspected of hitting their head, e.g. an unwitnessed fall, registered nursing staff are to clinically monitor the resident every shift for seventy-two hours. The policy states, monitoring included, vital signs, assess for pain, bruising, changes in functional status, cognitive status, and changes in range of motion. The policy further directs that if there is a change in the resident's vitals, neurological assessment or health status, a physician was to be notified.

Resident #002's Substitute Decision Maker (SDM) voiced concerns that resident had fallen several times while residing at the long-term care home.

The clinical health record documented the resident incidents and indicated all were unwitnessed.
The Director of Care-Quality (DOC-Quality) confirmed the 72 hours post falls monitoring for the resident following the incidents had not been completed based on the licensee's policy; nor had the physician

been notified when resident experienced changes in their health status post incident.

Failure of registered nursing staff to monitor a resident post fall, and to notify a physician following changes in a resident's health, places residents at risk for harm and delays potential medical assessment and treatment which may be warranted.

**Sources:** Review of clinical health record for a resident; interviews with resident's SDM and management. [000722]

## WRITTEN NOTIFICATION: Doors in a home

**NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

1.The licensee failed to ensure that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

**Rationale and Summary:**

A door which led to a non-residential hallway was observed ajar and not locked daily throughout this inspection. The kitchen door, within the non-residential hallway, was observed open on two separate occasions.

Staff and the ESM confirmed that the kitchen door was to be closed and locked.

Environmental Services Manager (ESM) indicated being aware that the door to the non-residential area did not fully close and confirmed that the door did not lock. The ESM confirmed the hallway was a non-residential area. The ESM indicated that the door, leading to the non-residential hallway, had not closed nor locked since their employment with the home.

Doors, in non-residential areas, that are not kept closed and are unlocked place residents at risk for potential harm and or injury.

**Sources:** observations throughout the inspection, and interviews with staff and management. [000722]

2.The licensee failed to ensure that doors leading to non-residential areas were equipped with locks to

restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

**Rationale and Summary:**

A servery door, leading to a residential hallway, was observed open, there were no staff in the servery during the observation. Residents were observed wandering past the servery door.

A Dietary Aid (DA) indicated the servery was a non-residential area and indicated that the servery door was to be closed and locked when staff were not in attendance. The DA indicated that the severy door was broken and did not close on its own. The DA indicated that staff must remember to pull the door closed when they are not in the servery. DA indicated that they had forgotten to close the door when they went to clean the dining room.

The ESM indicated that the severy door is not a self-closing door, and that dietary staff must pull the servery door closed and lock it when not in the servery. ESM confirmed that the severy is a non-residential area.

Doors, in non-residential areas, that are not closed and are unlocked place residents at risk for potential harm and or injury.

**Sources:** observations during the initial tour of the long-term care home, and interviews with staff and management. [000722]

3.The licensee failed to ensure that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

**Rationale and Summary:**

A door leading to a service hallway was observed open. Signage indicated ‘employee’s only beyond this point’. The Environmental Service Manager’s (ESM) office and the maintenance room door were observed open and unattended. During the same observation, an unlocked housekeeping (HSK) cart was observed unattended in the service hallway. Residents were observed wandering in the main foyer adjacent to the service hallway.

ESM confirmed that the service hallway was a non-residential area, and indicated the doors to their office, and maintenance room should not have been left open and unlocked. The ESM further indicated

the HSK cart should not have been unlocked when HSK staff were not in attendance.

Doors, in non-residential areas, that are not closed and are unlocked place residents at risk for potential harm and or injury.

**Sources:** Observations of a non-residential area; and interviews with staff and management. [000722]

## WRITTEN NOTIFICATION: Communication and response system

**NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 20 (e)

The licensee failed to ensure that the home was equipped with a resident-staff communication response system in every area accessible by residents.

**Rationale and Summary:**

During the initial tour of the long-term care home, residents and their families were observed sitting outdoors on patio's, these areas were intended for resident use. Residents were observed sitting outdoors on the patio, eating with their family. A resident-staff communication and response system were not observed available to resident's or their families, on either of the two patios located at the front or side of the home.

Residents, as well as their families, indicated they often sat outdoors on the patios. Residents and families interviewed indicated if they needed help, they would have to go into the home to access staff's assistance.

The Environmental Services Manager (ESM) indicated they did not know that resident-staff communication system was required in outdoor resident spaces. Senior Director of Care (SR DOC) indicated the outdoor patios are resident accessible, and confirmed the two outdoor patios did not have a resident-staff communication and response system available for resident use.

Failure to have a resident-staff communication and response system in all accessible resident areas, including outdoor spaces, places residents at risk of delayed staff assistance and potential harm.

**Sources:** Observations; interviews with residents, families, staff and management. [000722]

## WRITTEN NOTIFICATION: Air temperature

**NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 24 (1)

The licensee failed to ensure that the home was maintained at a minimum of 22 degrees Celsius.

**Rationale and Summary:**

A resident indicated that the home was frequently cold in the mornings. Resident indicated they struggle to turn the incremental heating/cooling unit on to warm up their room, indicating when they do get the unit turned on, staff turn it off. The incremental unit in resident's room was observed to be turned off.

Temperature Reports completed by a contracted service provider were reviewed. Temperature Reports reviewed identified dates, times, and locations when the air temperature in resident bedrooms and lounges were recorded below 22 degrees Celsius, for extended periods of time. The reports failed to identify corrective action had been taken to rectify the air temperatures being below legislated requirements.

Environmental Services Manager (ESM) indicated the air temperature in the long-term care home was maintained at a minimum of 22 C, and the air temperature was recorded and monitored in four (4) resident rooms, the dining room and lounges by maintenance staff and the contracted service provider. ESM indicated they are advised by the contracted service provider if the air temperature in the home drops below 22 C, and in turn they would advise maintenance staff to adjust temperatures and monitor. ESM indicated they could not recall any dates or times in the past six months where there had been issues with maintaining air temperatures in the home.

A maintenance staff indicated air temperature is taken and recorded once daily by maintenance. Maintenance staff indicated there was no set schedule, they simply choose a location in the home, take and record the temperature. Maintenance confirmed that air temperature was recorded throughout the day by an outside provider. Maintenance staff indicated they were unaware of dates or times, in the past year, when the air temperature in home had been below 22 C.

Failure of the licensee to maintain air temperatures at a minimum of 22 degrees places residents at risk of discomfort.

**Sources:** Review of air temperature logs, taken by a contracted service provider, for an identified period of time; interviews with a resident, staff and management. [000722]

## WRITTEN NOTIFICATION: Transferring and positioning techniques

**NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 40

1.The licensee failed to ensure that safe transferring and positioning devices were available to a resident.

**Rationale and Summary:**

A multifaceted complaint was received by the Director, one of the concerns was related to a resident incident.

Resident #003 was admitted to the long-term care home. Resident was a known safety risk and required the use of a mobility aid to assist with ambulation.

Physiotherapist (PT) assessed the resident on admission and indicated resident was a safety risk and required a mobility aid and the assistance of one staff for activities of daily living.

The resident had an unwitnessed incident. Documentation by a Registered Practical Nurse (RPN) and PT indicated that resident had been disoriented at the time of fall and was looking for their mobility aid, documentation indicated resident's mobility aid was in the corner of the resident's bedroom, not at the resident's bedside.

Personal Support Workers, Registered Nursing Staff and the contracted service provider indicated resident's mobility aid was not kept at their bedside in an attempt to encourage resident to seek staff assistance with transfers. A PSW indicated the resident rarely rang for assistance from staff and was doubtful that the resident could do it. PT confirmed the mobility aid was kept out of resident's reach to discourage self-transfers.

Failure to have a resident's mobility aid within reach contributed to the resident incident and placed resident at risk of injury.

**Sources:** Review of a resident's clinical health record; and interviews with staff and PT. [000722]

2.The licensee failed to ensure that safe transferring and positioning devices or techniques were in place for a resident.

**Rationale and Summary:**

The licensee’s policy, Falls Prevention and Management Program indicated the Falls Prevention and Management Program will engage resident, family/SDM and the interdisciplinary team to proactively identify and address individual and environmental risk factors and causes of falls; promote use of universal fall precautions to complement interventions based on individualized assessment and care planning and optimize resident functional status; and address injury prevention, including access to and appropriate use of mobility, transfer and positioning devices.

The clinical health record was reviewed and identified resident #002 was admitted to the long-term care home and was assessed at risk for safety. The health record indicated resident’s Substitute Decision Maker (SDM) communicated on admission that resident required a mobility device to assist with transferring into and out of bed; the health record identified SDM's request was denied. The health record indicated resident had incidents on three separate occasions while attempting to self-transfer. The health record further details the resident tipped a piece of furniture over while attempting to use it, to self-transfer; the incident resulted in resident sustaining an injury.

SDM confirmed they had communicated the need for an mobility aid to aid with resident transferring into and out of bed on admission, during residents residency at the home and following each incident; SDM indicated all requests for the mobility device were denied by registered nursing staff and management of the home. SDM voiced frustration, indicating it was their belief that not having access to a mobility device contributed to the resident's incidents.

Director of Quality (DOC-Quality) and the Physiotherapist (PT) indicated that a mobility device was not considered as an intervention to optimize resident's functional status or as a safety intervention, as mobility device was not permitted in LTCH as it was a restraint-free home. The Senior DOC confirmed the mobility device was not permitted to be used in Extendicare Homes, as such were deemed to be restraints.

Failure to allow residents to access and use mobility, transfer and positioning devices based on individualized needs reduced resident's functional status and most importantly placed the resident at risk for injury.

**Sources:** Review of a resident’s clinical health record, the licensee's Falls Prevention and Management

Program; interviews with a SDM, PT and management. [000722]

## WRITTEN NOTIFICATION: Personal care items and personal aids

**NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

The licensee failed to ensure that each resident had their personal care items labelled.

**Rationale and Summary:**

During the initial tour, and subsequent observations of the long-term care home (LTCH), resident personal care items were observed to be unlabeled in shared resident bedrooms. Personal care items were observed in two shared resident washrooms, where residents had been assessed to be under infection prevention and control precautions (IPAC).

Personal Support Workers (PSW), Manager of Quality, IPAC Lead and the IPAC Corporate Consultant confirmed that personal care items were to be individually labelled for resident use. IPAC Corporate Consultant indicated unlabeled personal care items had been discussed with the IPAC Lead during a previous visit to the LTCH, with the expectation that action would be immediately taken to resolve the deficiency.

The IPAC Lead, for the LTCH, indicated being aware that personal care items were unlabeled in the home, and confirmed it was a concern raised, by the IPAC Corporate Consultant, a few months ago. IPAC Lead indicated there had been no plan developed to resolve the concern and such was an area of improvement within the LTCH.

Unlabeled personal care items places residents at risk for infections, especially when unlabeled in shared resident spaces.

**Sources**: Observation of unlabeled personal care items; review of the clinical record for two resident identified to be under IPAC precautions; and interviews with staff and management. [000722]

## WRITTEN NOTIFICATION: Food production

**NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 78 (4) (b)

1.The licensee failed to ensure that food and fluids in the production system are stored and served using methods to prevent food borne illness.

**Rationale and Summary:**

During two meal service observations, on the same day, the milk, chocolate milk, creamer and Lactaid milk were observed being served at room temperature. The beverages were not observed in a cooling unit, or on ice prior to, during or following meal service.

During another meal observation, on a separate date, a pitcher containing milk, and a second unopened bag of milk were observed on a cart, both the pitcher and the bag of milk were being stored at room temperature.

A Dietary Aid (DA) indicated that milk, Lactaid milk and the creamer were to be stored and served in insulated cooling bins during meal service; DA indicated that that they had forgotten to retrieve the insulated cooling bin from the freezer that day.

Dietary Manager, as well as the Corporate Registered Dietitian (RD) Consultant, both confirmed that beverages such as milk, creamer and Lactaid milk are to be served at mealtimes and during nourishment in the cooling bins or in an ice bath and promptly returned to the refrigerator following service times.

Failure to store and serve fluids at proper temperatures placed residents at risk for foodborne illness.

**Sources:** Observations during meal service on one resident home area; interviews with staff and management. [000722]

2.The licensee has failed to ensure that food and fluids on the production system were stored and served using methods to prevent adulteration, contamination and food borne illness.

**Rationale and Summary:**

On four separate dates planned meal items, consisting of hot oatmeal, scrambled eggs and poached eggs were observed being delivered by the dietary staff from the main kitchen of the long-term care home, to a severy; the prepared hot meal items were observed inside steel containers with lids and transported to the servery on a plastic food cart. Neither the containers nor the food cart was intended to keep foods hot during transport.

Dietary staff indicated that insulated containers are not used to transport planned breakfast menu items to individual resident serveries. Dietary staff indicated that it is their routine practice to transport breakfast items using covered containers and a plastic food cart; staff indicated that the insulated carts were only used at lunch and dinner.

Dietary Manager confirmed the insulated carts were only used for transporting lunch and dinner food items from the kitchen to each unit servery.

Corporate Registered Dietitian (RD) Consultant indicated that all planned menu items, hot and cold, are to be transported from the main kitchen to individual unit serveries using the insulated cart; Corporate RD Consultant indicated that the method aids in maintaining appropriate food temperatures and prevents possible food borne illnesses. The Corporate RD indicated that the method, the home is currently using, to transport prepared breakfast food, from the kitchen to the individual unit serveries was not an appropriate method to transport food safely.

Failure of the long-term care home to utilize food storage containers for the transportation of the prepared hot and cold breakfast menu items, from the kitchen to unit serveries, poses food safety risks for residents.

**Sources:** Observations during four separate dates; interviews with staff and management. [000722]

## WRITTEN NOTIFICATION: Housekeeping

**NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)

The licensee failed to ensure that housekeeping procedures which had been developed were implemented, specifically related to odours in resident bedrooms.

Housekeeping is an organized program under clause 19 (1) (a) of the Act.

**Rationale and Summary:**

The licensee’s policy, Odours, directs that all lingering odours will be investigated. The policy states that all staff will immediately report any lingering odour to the Support Services Manager or designate; and that the Support Services Manager or designate will investigate the source of the odour and make appropriate referrals.

Throughout the inspection, an offensive and lingering odour was detected on a resident unit. A Personal Support Worker (PSW) indicated that the odour was most likely coming from the washroom in an identified resident room.

As the Inspector entered the identified resident bedroom, the odour grew worse and worsened as they entered the resident's washroom. The flooring of the washroom was observed to be wet in front of and around the toilet, and under the sink. An unknown fluid was observed seeping from underneath the flooring tiles, in front of the toilet and under the sink, as the Inspector walked into the washroom.

PSW's, a Housekeeping Aid (HSK) and maintenance staff indicated that the fluid seeping from beneath the tiled flooring in the resident's washroom was 'urine'. HSK indicated the washroom floor is cleaned daily and a deodorizing spray is used, but both interventions were of short duration. HSK and Maintenance indicated that the odour is coming from beneath the floor tiles. Staff interviewed indicated the odour has been an ongoing concern for well over a year; and indicated concerns regarding the odour had been communicated to registered nursing staff, the Environmental Service Manager (ESM) and the former Executive Director without resolution.

ESM confirmed being aware of the odour in the residents washroom, and indicated there were no plans in place to resolve the odour emanating from the washroom.

Offensive and lingering odours pose an infection prevention and control issue, and of utmost concern create an unpleasant living environment for residents.

**Sources:** Observations on a resident unit and in a resident bedroom/washroom; and interviews with staff and management. [000722]

## WRITTEN NOTIFICATION: Maintenance services

**NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (c)

1.The licensee failed to ensure that procedures were implemented to ensure the air conditioning systems were in a good state of repair.

**Rationale and Summary:**

During the initial tour of the long-term care home, the Packaged Terminal Air Conditioner (PTAC) units, in a resident lounge, dining room and four resident rooms were observed to have no mode selector or thermostat switches on the units. The PTAC units observed were in the ‘off’ mode.

Residents confirmed the PTAC units in their rooms had no control switches to operate the units; residents indicated being frustrated that they were unable to operate the PTAC units themselves and further indicated the PTAC units were usually not on. One resident indicated although it’s a struggle, they have found a way to turn on the PTAC units, by using a hand-held paper puncher.

A Personal Support Worker (PSW) indicated being uncertain why the PTAC units had no control switches. PSW confirmed the PTAC unit in one identified resident room was off and was unsure how to turn the PTAC unit on without the control switches. A PSW indicated that the PTAC unit control switches had been removed years ago by management; and indicated that without control switches the residents, families and staff would be unable to turn units on or off or make adjustment in their room temperatures. A PSW indicted they had discovered that they can turn on PTAC units, using a fork or a set of nail clippers.

Maintenance staff confirmed that the many of the PTAC units had no control switches; and indicated the PTAC units are not operational to residents, families, and staff without the control switches.

The Environmental Services Manager (ESM) and Senior Director of Care (DOC) indicated the long-term care home was fully air conditioned; both indicated the PTAC control switches had been removed years ago, to prevent residents, families and staff from adjusting air temperature in resident rooms, lounges and dining rooms.

There were a minimum of fifty PTAC units in resident rooms and lounges without control switches to enable operation of the units, numerous units were observed to be turned off.

PTAC units without control switches render units in operational for residents, their families and staff. PTAC units in operational, especially during hot weather, placed residents at risk for heat related illness.

**Sources:** Observations of resident rooms, lounges, and dining rooms, during the initial tour of the home; interviews with residents, staff and management. [000722]

2. The licensee failed to ensure that procedures were implemented to ensure the air conditioning systems were in a good state of repair.

**Rationale and Summary:**

On June 1, 2023, temperatures outdoors were 32 degrees' Celsius; heat advisory had been issued by Environment Canada for the Peterborough area.

Five residents and a Substitute Decision Maker (SDM) were complaining that the long-term care home was extremely warm. Residents indicated that the PTAC units in their rooms had no control switches to allow them to adjust the air temperature to cool. A resident indicated the PTAC unit in their room was turned off.

Personal Support Workers (PSW), and maintenance staff confirmed that many of the PTAC units in resident rooms, lounges and dining rooms had no control switches for operating the units. All indicated that management were aware that many of the PTAC units were without control switches, as management had removed the control switches.

On June 1, 2023, air temperatures in six resident rooms were recorded by Inspector and a maintenance staff to be above 26.5 degrees Celsius. PTAC units in these rooms were turned off and had no control switches to allow residents, their families, or staff to operate the units.

On the same date, concerns regarding several air conditioning units (PTAC) not being turned on, and numerous units having no control switches rendering the unit in operational, were communicated to Environmental Services Manager (ESM), Acting Executive Director (ED), Senior Director of Care (DOC), Operations Manager for Extendicare Peterborough and the Regional Operations Manager for Extendicare. Regional Operations Manager indicated that the PTAC units were operational and argued that the legislation did not specify that the units had to have control switches for residents to use them.

On June 1, 2023, the home was directed to have all air conditioning units turned on and operational, including control switches, by June 2, 2023, at 1030 hours.

On June 2, 2023, maintenance staff and the Acting Executive Director (ED) confirmed that all PTAC units had been turned on and had at least one control switch was available for residents, their families and staff use. Maintenance staff indicated that four PTAC units were discovered not working in two resident rooms and a unit in two resident lounges; maintenance confirmed that new PTAC units had been installed that morning in the identified resident rooms and lounges.

Failure of the licensee to ensure air conditioning units were operational placed residents at risk of harm, specifically heat related illness.

**Sources:** Observations of PTAC units in the long-term care home, recorded air temperatures, interviews

with residents, staff and management. [000722]

## WRITTEN NOTIFICATION: Hazardous substances

**NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 97

The licensee failed to ensure that all hazardous substances at the home were labelled properly and kept inaccessible to residents at all times.

**Rationale and Summary:**

An unsupervised housekeeping (HSK) cart containing hazardous substances was observed in a non-residential service area hallway. The HSK cart was unlocked and the service hallway door was propped open. Residents were observed wandering within the front foyer adjacent to the hallway.

The Environmental Services Manager (ESM) confirmed that the housekeeping cart contained hazardous substances and should not have been left unlocked when staff were not in attendance.

Failing to ensure that hazardous substances were labelled and kept inaccessible to residents, placed residents at harm of accidental ingestion, inhalation and contact with hazardous agents.

**Sources:** Observations of the HSK cart belonging left unattended and unlocked; review of the MSDS for four hazardous substances; and interviews with staff and management. [000722]

## WRITTEN NOTIFICATION: Police notification

**NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 105

1.The licensee failed to ensure the police were immediately notified of any alleged incident of abuse of a resident.

**Rationale and Summary:**

A multifaceted complaint was received by the Director, one of the concerns was related to an alleged abuse of resident #002.

Documentation by an RPN indicated, the Substitute Decision Maker (SDM) for a resident voiced concern regarding staff to resident abuse. Documentation by RPN indicated the abuse allegation and their assessment were communicated to a Charge Nurse-RN and Director of Care. There was no documentation in the clinical health record that police were notified of the alleged abuse.

The Director of Care-Quality indicated that police were not notified of the alleged abuse, and indicated the incident should have been reported.

Failure to notify police of incidents of alleged abuse places residents at risk of harm and delays potential investigations by authorities.

**Sources:** Review of a resident's clinical health record; interviews with an SDM for the resident and management. [000722]

2.The licensee failed to ensure the police were immediately notified of any alleged incident of abuse of a resident.

**Rationale and Summary:**

Documentation, in a resident's clinical health record identified that resident #002 reported to a Registered Practical Nurse (RPN) that they were being allegedly abused by staff. Later that same day, another RPN documented the resident had complained that a couple entered their room and abused them, documentation indicated resident described the individuals to the RPN. Documentation the next day, identified the resident continued to voice fear about an unknown individual entering their room.

The Director of Care-Quality indicated that police were not notified of the alleged abuse, and the incident should have been reported.

Failure to notify police of incidents of alleged abuse places residents at risk of harm and delays potential investigations by authorities.

**Sources:** Review of a resident's clinical health record for resident; interviews with SDM for the resident and management. [000722]

## WRITTEN NOTIFICATION: Dealing with complaints

**NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

1.The licensee failed to ensure that a verbal complaint made to the licensee or staff of the home concerning the care of a resident, specifically an allegation of resident abuse, was immediately investigated and a response provided within 10 business days of the complaint being received.

**Rationale and Summary:**

Resident #002's Substitute Decision Maker (SDM) indicated the resident had voiced being fearful of staff at the long-term care home (LTCH).

The clinical health record, for the resident was reviewed. The review identified, resident's SDM voiced concern to a Registered Practical Nurse (RPN) that resident had alleged abuse by staff during care. The clinical health record identified an RPN had assessed the resident, documented their findings and had communicated the alleged resident abuse to a Registered Nurse-Charge Nurse (RN) that shift, as well as the Director of Care (DOC).

The licensee's Complaint Log was reviewed. The review failed to identify the alleged staff to resident abuse had been investigated, nor a response provided to the SDM.

Director of Care-Quality (DOC-Quality) indicated recall of the SDM's concerns, specifically that alleged abuse, and indicated it was the responsibility of the Director of Care to investigate and respond to abuse allegations. DOC-Quality and the Senior DOC indicated there was no documentation regarding the complaint, surrounding the alleged staff to resident abuse, nor could they locate any documentation of a response to resident's SDM.

Failure of the licensee to investigate concerns, specifically surrounding alleged abuse of a resident, placed the resident at further risk of harm and conveyed to resident and SDM their concerns were of unimportance. Furthermore, failure of the licensee to respond to concerns jeopardizes mistrust and confidence in staff, management, and the licensee.

**Sources:** Review of a resident's clinical health record, and the internal Complaint Log binder; interviews with management. [000722]

2.The licensee failed to ensure that a verbal complaint made to the licensee or staff of the home concerning the care of a resident #002 was investigated and a response provided within 10 business days of the complaint being received.

**Rationale and Summary:**

Resident #002's Substitute Decision Maker (SDM) indicated they had voiced several concerns, regarding the care of a resident and the operations of the home. SDM indicated concerns had been voiced to staff and management of the long-term care home (LTCH) without response.

The clinical health record for a resident was reviewed, and identified the resident's SDM had voiced several concerns, regarding resident care and operations of the home to a Registered Practical Nurse (RPN).

The licensee's Complaint Log was reviewed. The review failed to identify concerns voiced by resident's SDM had been investigated nor a response provided.

Physiotherapist (PT), and the Director of Care-Quality (DOC-Quality) indicated recall of the SDM's concerns, specifically those surrounding resident mobility, resident incidents, and the request for a mobility aid. DOC-Quality indicated concerns brought forth had been communicated to the Director of Care and the Executive Director (ED), via email, without response. DOC-Quality confirmed the SDM voiced numerous concerns regarding the care of the resident, indicating they could not speak to what had not been documented by former management.

Senior DOC indicated that if there was no documentation on file, they'd presume an investigation of concerns were not investigated, nor a response provided to SDM.

Failure of the licensee to investigate and respond to resident and their SDM's conveys the concerns brought forward were of unimportance. Furthermore, lack of response to concerns raised by resident and family jeopardizes trust and confidence in staff, management, and the licensee.

**Sources:** Review of the internal Complaint Log binder, the clinical health record for a resident; interviews with resident's SDM, PT, staff and management. [000722]

## WRITTEN NOTIFICATION: Dealing with complaints

**NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee failed to ensure that a documented record is kept in the home that includes, the nature of

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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 and a description of the response; and any response made in turn by the complainant.

**Rationale and Summary:**

Resident #001 and their Substitute Decision Maker (SDM) indicated they had voiced several concerns to registered nursing staff, and the Dietary Manager regarding meal service without resolution.

The home's Complaint binder for 2022 and 2023 was reviewed. The review failed to identify any documented complaints regarding food service.

Dietary Manager confirmed that the resident and their SDM had voiced several concerns regarding food service. Dietary Manager indicated the verbal concerns had not been documented, including the nature of the complaint, dates of receipt, follow-up action or resolution, nor had there been a response provided to resident or their SDM. Dietary Manager indicated concerns were isolated to the resident and a few other residents in the one resident dining room, not the entire home.

Senior Director of Care, for Extendicare, indicated that ongoing verbal concerns are to be documented, including a description of the concern, date received, dates action taken and response to the complainant.

Failure to document concerns, specifically the nature of the concern, action taken and response to residents and their SDM poses potential conflict in care and service relationships, and of utmost importance the affects quality of life for the resident.

**Sources:** Review of home's Complaint Log; interviews with a resident, their SDM and management. [000722]

2.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; action taken to resolve the complaint, including date, action and follow-up action required; final resolution, if any; every date on which a response was provided to the complainant; and the complainants response.

**Rationale and Summary:**

Resident #002's Substitute Decision Maker (SDM) indicated they had voiced several concerns, regarding

the care of the resident and the operations of the home. SDM indicated concerns had been voiced to staff and management of the long-term care home (LTCH) without response.

The resident's clinical health record was reviewed. The review identified resident's SDM had voiced concerns regarding the care and operations of the long-term care home to registered nursing staff and managers.

The licensee's Complaint Log binder, for 2022 and 2023 was reviewed. The review failed to identify any documented concerns by the resident or their SDM.

Director of Care-Quality (DOC-Quality) confirmed being aware of ongoing care concerns voiced by resident's SDM; DOC-Quality indicated the logging of Complaints was the responsibility of the Executive Director.

The Senior Director of Care (SR DOC) indicated they could not speak to what was not documented by the former Executive Director but confirmed that all ongoing verbal complaints and all written complaints were to be documented in the internal Complaint Log binder.

Failure of the licensee to document nature of verbal and written concerns, action taken and response poses potential the inability to recognize areas of required improvement in care and services afforded to those residing in the long-term care home.

**Sources:** Review of the internal Complaint Log binder, and a resident's clinical health record; interviews with resident's SDM, and management. [000722]

## WRITTEN NOTIFICATION: Administration of drugs

**NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 140 (6)

The licensee failed to ensure that a resident did not administer a drug to themselves without the approval of a physician.

**Rationale and Summary:**

A Registered Practical Nurse (RPN), Director of Care-Quality (DOC-Quality) and the Senior Director of Care indicated that it was their belief resident #003 was self-administering medications not prescribed

by the resident's physician.

A resident confirmed having occasionally self-administering medication for comfort since their admission to the long-term care home. Resident voluntarily pulled a bottle of medication from their person, the pharmacy label on the bottle identified the medication and that the medication had been ordered for the resident by a previous physician. Resident confirmed having no orders to self-administer medications.

Registered nursing staff, DOC-Quality and the Senior DOC, all confirmed the resident did not have an order to self-administer the medication.

The self-administering of drugs without the approval of a physician placed the resident at risk for harm; having medications in an unsecured and locked location placed other residents at risk of harm.

**Sources:** Observations; a review resident's clinical health record; and interviews with a resident, registered nursing staff and management. [000722]

## COMPLIANCE ORDER CO #001 Right To Quality Care And Self-Determination

**NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 3 (1) 23.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee is ordered to comply with the following:

1. Resident #003 must be assessed by an occupational therapist (OT) as to their needs and safety, including preference surrounding, transferring, toileting and repositioning. This assessment must be completed within 2 weeks of receipt of this order. Should a transfer pole, assist bed rail(s) or alternate mobility device or aid be required, the Physiotherapist, Physiotherapist Aid, Registered Nursing Staff, and the management team will work with the OT and the resident to ensure the resident receives care and assistance towards independence and a restorative care philosophy. The assessment will be documented, recommendations developed, consented to by the resident, and implemented within 1 week of the OT assessment. The resident's plan of care will be reviewed and revised as required by the legislation. The assessment, implemented plan and collaboration of the interdisciplinary team is to be documented, kept, and made immediately available to the Inspector upon request.

2. The licensee will review their 'restraint-free' policy, keeping in mind individualized needs and preferences of each resident or their Substitute Decision Maker. Any revision will be communicated to all nursing staff, managers and others as needed. The review and any communication will be documented, kept, and made immediately available to the Inspector upon request.

3. All nursing staff, nursing managers and supervisors, including the Director of Care-Quality and Director of Care, Executive Director and any other staff as needed are to be re-trained on restraints and personal assistive safety devices (PASD), as well as the licensee policies and procedures related to such. Importance should be around resident needs, re-assessment of resident's needs, safety around care implemented and monitoring of planned care. This re-training will be documented, kept, and made immediately available to the Inspector upon request.

**Grounds**
The licensee failed to ensure a resident received the right to care and assistance towards their independence based on a restorative care philosophy to maximize their independence.

**Rationale and Summary:**

Resident #003 was admitted to the long-term care home (LTCH). Resident was transferring independently prior to their admission using mobility aid-device.

On admission to the LTCH, resident and their family were told, by the Admission Coordinator-RPN and the management, they could not use the mobility aid-device. Resident indicated being told the mobility aid-device were restraints, and the LTCH was a restraint-free home. Resident indicated they were told staff would assist with transfers. Resident indicated their goal in moving into long-term care (LTC) was to restore their independence to a greater extent, not to be reliant on staff assistance for transfers.

Physiotherapist (PT) indicated that a mobility aid-device could benefit resident's restorative ability for transfers; and confirmed the resident had not been assessed for a mobility aid-device as the home is restraint-free. Admission Coordinator, Director of Care-Quality (DOC-Quality) and the Senior Director of Care (SR DOC) confirmed the resident was denied the use of a mobility aid-device on admission due to entrapment risk and the home having a restraint free home policy.

Resident indicated their admission to LTC has negatively impacted their independence to self-transfer by being denied use of mobility devices to transfer.

Failure of the licensee to afford resident #003 the right to receive care and assistance, specifically the use of mobility aid-device, based on a restorative care philosophy negatively affected resident's

independence and sense of well-being.

**Sources:** Observations resident’s room; review of resident’s clinical health record; interviews with the resident, resident's family, PT, staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #002 When reassessment, revision is required

**NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee is ordered to comply with the following:

1.The plan of care for resident #003 is to be reviewed and revised, within 1 week of receipt of this order, ensuring identified interventions are effective and include non-pharmacological and pharmacological interventions to be taken should the resident indicate they remain in discomfort, including contacting of a physician or nurse practitioner for direction. Documentation is to be kept and made immediately available to the Inspector upon request.

2.Identified assessment are to be completed twice daily, as well as each time an identified PRN medication is administered to resident #003; assessments are to be completed for 4 weeks.
The identified assessment and related documentation of resident's discomfort will include a description of the discomfort, its location and intensity including pain score pre-medication; if a PRN medication is administered to resident #003, documentation will further document the effectiveness of the medication, pain score post medication, and action taken should the resident's discomfort not be relieved.
If registered nursing staff cannot complete the required pain assessment as ordered, due to resident #003 being on a leave of absence (LOA), registered nursing staff will appropriately document in the resident’s clinical health record the rationale for the pain assessment being incomplete. Registered nursing staff will document, the resident as being on LOA as of [date], with expected return [date]. Pain assessment are to resume, as ordered, upon resident’s return from LOA. Documentation MUST be documented in the clinical health record for the resident, each shift that the resident was absent for.
The Director of Care or their designate will audit the identified assessments, for resident #003, for a period of 4 weeks to ensure identified assessments have been completed and any unrelieved discomfort communicate to a physician, or nurse practitioner. Documentation is to be kept and made immediately available to the Inspector upon request.

3.Registered nursing staff, nursing supervisors and managers will be re-trained on licensee's Pain Management Program, including types of pain, the assessment and reassessment of a resident experiencing pain, interventions to be taken if non-pharmacological or pharmacological interventions are ineffective, including contacting a physician or a nurse practitioner for further direction. The re-training must include, the importance of pain assessments being objective and based on what the resident says they are experiencing. Documentation is to be kept and made immediately available to the Inspector upon request.

**Grounds**
The licensee failed to ensure a resident was reassessed and the plan of care reviewed when the care set out in the plan was ineffective.

**Rationale and Summary:**

Resident #003 voiced concerns that they were in constant discomfort and indicated it was affecting their overall enjoyment of life. Resident indicated they had been prescribed a routine and as needed medication, but commented the medication was ineffective. Resident indicated most of the registered nursing staff make them wait the full four hours before they will give them the PRN pain medication, and further commented, depending on which registered nursing staff were working, they may make them wait longer then the four hours for pain medication.

The clinical health record for the resident was reviewed.

Documentation in the resident's clinical health record identified resident complained of discomfort despite routine and as needed medication being administered. Documentation indicated the discomfort was affecting resident's activities of daily living. There is no documentation by registered nursing staff indicating the physician was contacted as to resident's concerns and/or when the prescribed medication had been ineffective.

Two Registered Practical Nurse (RPN) indicated being aware the resident had voiced concerns regarding their comfort and medication not being effective. Both RPN's indicated they believed the resident had been prescribed adequate medications; and further indicated the physician had not been contacted regarding the residents medication not being effective.

The Senior Director of Care (SR DOC) indicated the administering of as needed medication and contacting a physician for reassessment of medications or health concerns is based on the nurse's clinical judgement and individual assessments. SR DOC indicated several registered nursing staff believe

the resident was not in discomfort.

A referral to a specialist was requested by the resident, following the resident voicing ongoing concerns for approximately 44 days following their admission.

Failure of the licensee to adequately assess and manage the resident's discomfort contributed to resident's disinterest in their activities of daily living and decreased their overall sense of well-being.

**Sources:** Observations of the resident; review of the clinical health record; interviews with the resident, their family, registered nursing staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #003 Specific duties re cleanliness and repair

**NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee is ordered to comply with the following:

1. The washroom flooring in an identified resident room must be removed, sub-flooring cleaned, disinfected, or replaced, and a new washroom floor laid. The Environmental Services Manager (ESM) or their designate will ensure the areas between the flooring, toilet, sink and along baseboards are adequately addressed to prevent water and or other fluids from seeping beneath the flooring. All invoices will be maintained, demonstrating the work required was completed. Records are to be kept and made immediately available to the Inspector upon request.

2. The ESM or their designate will audit all resident washroom floors in the home, ensuring that each floor is in a safe condition and a good state of repair; this audit will be completed within 2 weeks of receipt of this order; audits must continue monthly until this order is complied. The audits will be documented, deficiencies noted, and corrective action taken. If repair or replacement is required, times lines are to be documented for completion of any noted deficiency, dates repair and replacement were completed and by whom. Any deficiency observed and noted in the audits must be repaired or replaced within 2 weeks. Records are to be kept and made immediately available to the Inspector upon request.

3. The Executive Director must sign off on audits, corrective action plans and any repair or replacements

completed.

**Grounds**
The licensee failed to ensure that the home was maintained in a safe condition and in a good state of repair.

**Rationale and Summary:**

Throughout this inspection, a pungent odour was detected while in a resident unit. A Personal Support Worker (PSW) indicated that the odour was most likely coming from a specific resident room.

The tiled flooring in the washroom, of a resident room, was observed to be heavily stained. The flooring was observed cracked and lifting to the front of and around the toilet; the flooring was observed wet in front of the toilet and extending under the sink. As the Inspector stepped into the washroom, an unknown fluid seeped from beneath the floor tiles onto the floor. The washroom had a lingering and offensive odour.

Staff interviewed indicated that the fluid seeping from beneath the tiled flooring in the resident's washroom was 'urine'. Staff indicated that the washroom flooring had been in a state of disrepair for over a year and indicated such was unacceptable for residents. Staff indicated the Environmental Service Manager (ESM) and the former Executive Director were aware of the disrepair.

ESM indicated being aware of the disrepair of the washroom flooring. ESM indicated there were no plans in place to repair or replace the washroom flooring in the identified resident room.

Operations Manager indicated being unaware of the disrepair in the washroom of the resident's room and indicated the condition of the washroom was unacceptable.

Failure to maintain flooring in a safe condition and good state of repair placed residents at risk for falls, specifically residents residing in the room. Lingering and offensive odours, as well as stagnant bodily fluids on and beneath floors poses a risk of infections to residents.

**Sources:** Observations of the resident room and washroom; interviews with staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #004 Cooling requirements

**NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 23 (4) (a)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee will comply with the following:

1. All registered nursing staff, maintenance staff and all management of the long-term care home will be provided re-training related to the licensee's Preventing Heat-Related Illness Program. The licensee will ensure that all required staff and managers are aware of their role and responsibility in keeping residents comfortable and safe The Executive Director will be responsible to ensure this re-training has been completed. The re-training is to be documented and kept for review by the Inspector.

2. Communication will be provided to all nursing and support staff as to their role and responsibility in keeping residents safe and comfortable during hot weather, including strategies to keep hot air temperatures to a minimum inside the home and keep residents hydrated. Any communication regarding Preventing Heat-Related Illness Program is to be retained, including dates in which communicated was circulated to staff. Documentation of the communication is to be kept for the Inspectors review.

**Grounds**
1.The licensee failed to ensure the heat related illness prevention and management plan for the home was implemented during the period of May 15 to September 15, specifically failed to ensure it was implemented, any day on which the outside temperature forecasted by Environment and Climate Change Canada when the area in which the home is located is 26 degrees or above.

**Rationale and Summary:**

The licensee's policy, Preventing Heat-Related Illness, directs that staff will be ready to monitor and respond to individual resident needs during hot weather, including measures to prevent heat-related illness. The policy indicated that prevention and early interventions should be aimed at cooling and rehydrating residents. The policy indicated the air conditioning was to be operational to maintain resident comfort.

The licensee's policy, Preventative Maintenance Program, directs that all homes shall have a preventative maintenance program that provides a scheduled system of inspections and maintenance,

and shall include but not limited to, heating, cooling and air conditioning equipment and systems. Procedures within this policy direct the Maintenance Manager or Lead will speak with residents prior to May 15th and after September 15th annually regarding air cooling preferences; residents may change their decisions at any time. The policy directs those conversations with the individual resident will be documented in Point Click Care (PCC).

An on-site inspection, of the long-term care home (LTCH), was initiated on May 17, 2023, and concluded June 2, 2023. During the initial tour of the LTCH, incremental cooling units in two resident lounges, and identified resident bedrooms were observed in the 'off' mode; the incremental units were further observed to have no thermostat control switches to turn the units 'on' or 'off' and/or to adjust air temperatures when the units were in the 'on' mode. On June 1st, additional incremental units in lounges and resident bedrooms, throughout the LTCH, were observed in the 'off' mode.

A review four resident's clinical health record failed to identify discussions had taken place with residents specific to air temperature preferences, prior to May 15, 2023.

A Personal Support Worker (PSW) confirmed the incremental cooling units in the resident lounge, on a resident unit, and an identified resident bedroom were in the 'off' mode. Maintenance staff indicated being unaware of the incremental units being turned to 'off' mode. Maintenance staff further indicated being unaware of any policy or procedure regarding speaking with individual residents prior to May 15th or after September 15th regarding air cooling preferences.

On June 1, 2023, identified the incremental cooling units in two resident lounges, and identified resident bedrooms remained in the 'off' mode; additionally, incremental units in six other resident bedrooms were also turned off.

Air Temperatures in the identified areas were taken and recorded, by Maintenance staff and the Inspector, and found to be above 26 degrees Celsius in a resident lounge and several resident bedrooms. Maintenance staff indicated they had been consumed with other home priorities and had not checked that all cooling units had been turned to the 'on' mode and adjustments made to temperature and fan speeds, prior to May 15th.

On June 1, 2023, the temperature listed by Environment and Climate Change Canada was 30 degrees Celsius in Peterborough, Ontario.

Failure to ensure the heat related illness prevention and management plan had been implemented as of May 15th, placed residents at risk for heat related illness.

**Sources:** Observations of incremental units in randomly selected resident bedrooms and lounges, temperatures taken and recorded on June 1, 2023; review of randomly selected clinical health records and licensee policies, specifically, Preventive Maintenance, and Prevention of Heat-Related Illness; and interviews with staff and maintenance. [000722]

2.The licensee failed to ensure the heat related illness prevention and management plan for the home was implemented during the period of May 15 to September 15, specifically failed to ensure it was implemented, any day on which the outside temperature forecasted by Environment and Climate Change Canada when the area in which the home is located is 26 degrees or above.

**Rationale and Summary:**

The licensee's policy, Preventing Heat-Related Illness, directs that staff will be ready to monitor and respond to individual resident needs during hot weather, including measures to prevent heat-related illness. The policy indicated that prevention and early interventions should be aimed at cooling and rehydrating residents. The policy indicated the air conditioning was to be operated to maintain resident comfort.

The licensee's policy, Preventative Maintenance Program, directs that all homes shall have a preventative maintenance program that provides a scheduled system of inspections and maintenance, and shall include but not limited to, heating, cooling and air conditioning equipment and systems.

An on-site inspection was initiated on May 17, 2023, and concluded June 2, 2023. During the initial tour and additional observations throughout the inspection, it was noted by the Inspector, several incremental cooling unit's resident lounges and bedrooms were dirty and in the 'off' mode. Initial concerns were addressed with the Environmental Services Manager (ESM) and the Senior Director of Care (SR DOC) on May 17, and May 23, 2023.

On June 1, 2023, the same incremental units observed May 17, 2023, and throughout the inspection remained in 'off' mode and dirty. Temperatures were taken and recorded by the Inspector, in a resident lounge and six resident rooms were identified to be above 26 degrees Celsius; maintenance staff confirmed air temperatures in four resident bedrooms were above 26 degrees Celsius, and that the incremental units in those bedrooms were in the 'off' mode.

Fifty (50) plus incremental units in the long-term care home were observed without thermostat control switches to allow residents and others to adjust temperature and fan speeds.

The licensee was directed, on June 1, 2023, to take immediate action to ensure that all air conditioning

units were cleaned, turned to 'on' mode and be equipped with thermostat control switches. The licensee was directed to have this action initiated and completed no later than June 2, 2023, at 1030 hours.

On June 2, 2023, maintenance staff indicated that because of direction given on June 1, 2023, four incremental cooling units were discovered to be non-operational. Maintenance staff indicated that an incremental cooling unit in two resident lounges were replaced, as well as a unit in two identified resident bedrooms. On this same day, residents complained that the dining room on a specific resident unit was too warm during meal service; it was identified that one of the incremental cooling units was blowing hot air. Maintenance indicated the home had no spare incremental units on site, but units had been ordered and the incremental cooling unit would be replaced, in the dining room, upon their arrival.

Maintenance Staff indicated the incremental units in resident bedrooms and lounges had not been checked to ensure they were operational by May 15th, as they were told there were other priorities in the home that required completion first.

On June 1, and June 2, 2023, the temperature listed by Environment and Climate Change Canada was 30 degrees Celsius in Peterborough, Ontario.

Failure to ensure the heat related illness prevention and management plan had been implemented as of May 15th, placed residents at risk for heat related illness and discomfort.

**Sources:** Observations of incremental units in randomly selected resident bedrooms and lounges; temperatures taken and recorded on June 1, 2023; review of licensee policies, specifically, Preventing Heat-Related Illness and Preventative Maintenance; interviews with staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #005 Menu planning

**NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 77 (5)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee is ordered to comply with the following:

1. The Dietary Manager will immediately review and revise production sheets for all menu cycles,

including forecasted quantities, to ensure there is enough planned menu items available to residents, based on current occupancy, the need for show plates, and the ability to offer residents second of their choosing. Records are to be kept and made immediately available to the Inspector upon request.

2. Meal service will be observed and audited daily in all dining rooms and at all meals from start to finish, by the Dietary Manager, Food Service Supervisor, other managers and supervisors, for a period of 4 weeks, including weekends and any holidays. Supervisors' must be registered staff, e.g. Registered Nurse, Registered Practical Nurse or Physiotherapist. The registered staff designate MUST receive training on how to properly conduct the audit prior to commencing the audits and records of the training details must be documented and kept. Audits will include, but not limited to planned menu items are prepared and available based on the posted menu, substitution of menu items if any, are communicated to the residents, seconds are offered to residents at all meals, and that food and fluids are being served within safe food temperature range. Records are to be kept and made immediately available to the Inspector upon request.

3. All audits will be documented, noting any deficiency observed, what corrective action was immediately taken and need for further review and follow-up by Dietary Manager, Food Service Supervisor, Registered Dietician (RD) and or Corporate RD Consultant. Audits, any deficiencies and correction action taken or needed will be discussed in the Daily Managers Meeting, and a weekly communication to dietary staff to ensure interdisciplinary collaboration is evident. Records are to be kept and made immediately available to the Inspector upon request.

4. The Dietary Manager or their designate will review the importance of forecasting quantities, adjusting quantities and documenting rationale for the adjustment in quantities and the accurate documentation of waste, this review will include all Cooks and other dietary staff as needed. This review will be documented, including staff name, role, date, and the person who met with each staff. Records are to be kept and made immediately available to the Inspector upon request.

5. The Dietary Manager will review the production sheets daily for 4 weeks, ensuring information regarding any adjustment in food quantity and waste has been documented. Concerns regarding documentation are to be addressed with dietary staff and documented, along with corrective action and the need for further monitoring if required. Records are to be kept and made immediately available to the Inspector upon request.

6. The Dietary Manager will continue to review and adjust production sheets, including forecasting quantities and waste, until this order is complied. Records are to be kept and made immediately available to the Inspector upon request.

**Grounds**
1.The licensee failed to ensure that planned menu items were offered and available at meal and snack service.

**Rationale and Summary:**

A complaint was received by the Director regarding meal service on a resident unit.

The planned main entrée, for the dinner meal service, was lasagna, Greek salad, and garlic bread. A Dietary Aid (DA) was overheard indicating, to Personal Support Workers (PSW), they had run-out of the Greek salad and garlic bread; only half of the residents had been served their dinner. Later, during the same meal service, DA indicated to a PSW that the lasagna, regular texture, was not available as an entrée option; four resident tables had not been served their meals.

DA indicated that insufficient quantities of food had been sent up from the kitchen.

Five residents, who reside on the identified unit, and PSW's indicated that there were often insufficient quantities of planned menu items available for residents at the dinner meal service. Residents voiced frustration their dinner meal choice was not available, indicating such had not been the first occurrence.

Having insufficient quantities of planned menu items available at meal service impacts the quality of services provided by the long-term care home, specifically a pleasurable dining service for residents residing in the home and poses the risk of residents refusing meals.

**Sources:** Observations of a meal service; review of daily and weekly menu posted; and interviews with residents, and staff. [000722]

2. The licensee failed to ensure that the planned menu items were offered and available meal and snack service.

**Rationale and Summary:**

A complaint was received by the Director regarding meal service on a resident unit.

The planned breakfast menu included poached eggs. A Dietary Aid (DA) was overheard commenting to a Personal Support Worker (PSW) they had run out of poached eggs. DA was heard indicating that residents requesting poached eggs, including those on tray service would need to select an alternate option.

DA confirmed that an insufficient quantity of poached eggs had been sent to the dining room.

A Cook indicated that insufficient food quantities, mainly at lunch and dinner, had been problematic and were not isolated to the one resident unit. The Cook indicated that insufficient food quantities at meal and snack service are related to the forecasted quantities not being reflective of the current resident occupancy, specifically the forty plus residents admitted to the long-term care home over the past few months. Cook indicated they had communicated, to the Dietary Manager, that forecasted quantities of planned menu items were insufficient and needed updating.

Corporate Registered Dietician (RD) Consultant, for Extendicare Canada, confirmed the production sheets, specifically the forecasted quantities of planned menu items were not accurate based on the home's current occupancy.

Having insufficient quantities of planned menu items available at meal and nourishment service, impacts a pleasurable dining service afforded to residents.

**Sources**: Observations of a meal service; review of the weekly and daily posted menu, food production sheets, including forecasting and left-over quantities; interviews with staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #006 Dining and snack service

**NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee will comply with the following order:

1.All dietary staff including, the Food Service Supervisor and the Dietary Manager are to be retrained on license policies surrounding food temperatures, including Temperatures of Food at Point of Service, Holding and Food Distribution, Temperatures and End Point Food Temperatures, to ensure awareness and willingness to comply with such. Documentation is to be kept, of this retraining, and immediately made available to the Inspector upon request.

2.The Dietary Manager or their designate will ensure all food thermometers have been calibrated, as per

manufacturer's instructions. Food Thermometers are to be calibrated, at minimum of weekly, and the calibration documented. Documentation is to be kept and immediately made available to the Inspector upon request.

3.The licensee will prepare a 4-week, schedule ensuring the Dietary Manager, Food Service Supervisor (FSS), or another manager/supervisor are present in the kitchen and in an identified servery at all mealtimes, including weekends and holidays. The Dietary Manager, FSS, or another manager/supervisor assigned will observe food temperatures are appropriately taken and recorded, including temperatures of food at point of service, holding and distribution temperatures and end point service temperatures. The manager/supervisor auditing food temperatures are taken, will ensure that dietary staff are following licensee policies for safe food handling, and take immediate action should safe food temperatures be out of the safe range. Food temperatures are to be taken and recorded for all planned menu items, any corrective action must be documented and communicated to the Cook, Dietary Manager and or Food Service Supervisor. Documentation is to be kept and immediately made available to the Inspector upon request.

4.The Dietary Manager, Food Service Supervisor or another manager/supervisor assigned will audit to ensure dietary staff, assigned to identified dining room, have turned on the steam table(s), to the appropriate setting, one hour prior to meal service to ensure food temperatures are maintained. This audit will be completed one hour prior to meal service for 4 weeks, including weekends and holidays. Documentation is to be kept and immediately made available to the Inspector upon request.

5.The Dietary Manager will immediately communicate to dietary staff that 'only approved transport systems' will be used to transport food from the kitchen to the unit severies. Documentation of this communication is to be kept and immediately made available to the Inspector upon request.

6.The Dietary Manger, Food Service Supervisor or another manager/supervisor assigned to meal service and temperature audits will ensure dietary staff are ONLY using approved food transport systems, to transport food from the kitchen to serveries. The use of approved transport systems is to be immediately implemented. Managers auditing meals and food temperatures, will document that an approved transport system was used by dietary staff; any corrective action will be documented. Documentation will be kept and immediately made available to the Inspector upon request.

**Grounds**

1.The licensee has failed to ensure that foods are served at a temperature that is both safe and palatable for residents.

**Rationale and Summary:**

Resident #001 and their Substitute Decision Maker (SDM) indicated food at the long-term care home (LTCH) is rarely warm when served, specifically during the lunch and dinner meal service. Resident and SDM indicated this have been an ongoing concern, which has been discussed with registered nursing staff and the Dietary Manager.

Six residents indicated that food, especially at lunch and dinner, were barely warm when served. Two residents indicated voicing their concerns to registered nursing staff, Food Service Supervisor (FSS) and the Dietary Manager in the past without resolution; they further indicated, on occasion, they've asked for their food to be reheated in the severy microwave but were told it was not permitted due to safety reasons. Residents voiced displeasure in having to eat meals cold.

Food temperature records were reviewed for the period of December 2022 to May 2023, and noted, that on occasion food temperatures were below the required temperature of 74 degrees Celsius; documentation reviewed failed to provide details of correction action taken.

The Dietary Manager indicated being aware that some residents, on a specific unit, had complained of hot foods being served cold, but they themselves had not been advised that food temperatures were outside of safe food temperature range by dietary staff.

Corporate Registered Dietitian (RD) Consultant confirmed that serving hot food outside of temperature ranges was not an appropriate practice nor the policy of the LTCH. Corporate RD Consultant indicated that corrective action should always be taken when food temperatures are not within safe temperature ranges.

Not maintaining safe food temperatures placed residents at risk of food related illness and created an unpleasable dining experience for residents.

**Sources**: Observation of meal services; review of food temperature logs; and interviews with residents, staff and management. [000722]

2. The licensee has failed to ensure that foods are served at a temperature that is both safe and palatable for residents.

**Rationale and Summary:**

Food temperature records were reviewed for the period of December 2022 to May 2023. The review identified numerous dates where cold food temperatures were recorded at temperatures above 4

degrees Celsius. Documentation failed to provide details of corrective action taken when food temperatures had not been within the safe food serving temperature ranges.

Dietary staff, Food Service Supervisor and the Dietary Manager indicated being aware of safe food temperatures for both hot and cold foods. All indicated that cold food was required to be maintained at 4 degrees Celsius or below.

FSS indicated being unaware of resident complaints related to food temperature but indicated being aware that cold menu items had been served, on occasion, at temperatures above 4 degrees Celsius. FSS indicated noting cold menu items had been outside of safe food temperature ranges when auditing food temperatures but indicated correction action had not been taken nor had the concern been communicated to the Dietary Manager. The Dietary Manager indicated being unaware of inconsistencies in cold food temperatures and indicated auditing of food temperatures records were the responsibility of the FSS.

Corporate Registered Dietitian (RD) Consultant confirmed that serving of food outside of safe temperature ranges were not an appropriate practice nor the policy of the home. Corporate RD Consultant indicated that corrective action should always be taken when food temperatures are not within safe ranges.

Food served outside of safe food temperature ranges placed residents at risk of food-borne illness.

**Sources:** Observation of meal services; review of food temperature logs; and interviews with dietary staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #007 Cooling requirements

**NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 23.1 (3)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee is ordered to comply with the following:

1. Maintenance Staff, Environmental Service Manager, and all management of the home are to review the licensee’s policy, Preventing Heat-Related Illness, ensuring they are aware of all policies, procedures,

and strategies The review is to be documented, including name and role, signature and date completed. The Executive Director is responsible to ensure all maintenance staff and managers have completed the policy review. The documentation is to be kept for Inspector's review.

2. Maintenance Staff and the Environmental Service Manager (ESM) are to audit each incremental cooling/heating unit in the home, ensuring they have been cleaned, and serviced, filters changed, and any parts repaired or replaced as required, including face plate, grill, and that each unit has a minimum of two (2) thermostat control switches. The audit is to commence upon receipt of this order, and to continue monthly without exception. Each individual unit is to have its own cleaning and servicing log, including the location of the unit, unit name, serial number, dates in which the unit was cleaned, serviced, filter change or replaced, parts repaired or replaced and who completed such. ESM and the Executive Director are responsible to ensure the initial, then monthly audits of all incremental units are completed and any corrective action resulting from the audits will be immediately rectified. The initial audit, and all cleaning and serving logs for each incremental unit, thereafter, are to be maintained, including any corrective action taken. Documentation must be available for review by the Inspector.

3. Maintenance staff and the Environmental Service Manager will audit to ensure all incremental units in the home are turned to 'on' mode, and that temperature and fan speeds have been adjusted to ensure resident comfort. This audit is to be completed daily for 1 week; then twice weekly for 2 weeks; then weekly for 4 weeks; then monthly thereafter; audits are to be documented for each incremental unit in the home. ESM and the Executive Director are responsible to ensure the audits have been completed, any corrective action taken and that such is documented. Documentation is to be kept for Inspector's review.

4. Air Temperatures are to be monitored and recorded in each resident's room three times daily to ensure cooling is at a comfortable level for residents. Continue to monitor and record air temperatures in resident's rooms for one month after compliance is achieved with this order. The temperature logs must be filed and maintained in the home.

5. Communication will be provided to all nursing, support staff and management measures to be taken when temperatures in resident's rooms, lounges, dining rooms and common areas exceed 26 degrees' Celsius. Documentation of the communication is to be dated and kept for the Inspectors review.

**Grounds**
The licensee failed to ensure the air conditioning was operating and used in accordance with manufacturer's instructions, in resident bedrooms and resident lounges. The licensee further failed to maintain the air conditioning at a comfortable level for residents and for the protection against heat related illness.

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

**Central East District**
33 King Street West, 4th Floor
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**Rationale and Summary:**

The manufacturer's instructions, for the incremental heating and cooling units were reviewed. The manufacturer directs that the air intake and air outlet must be kept clean and free of obstruction for the units to properly operate and to achieve the best results in cooling the room. The manufacturer's instructions direct that thermostat control switches, located on the control panel, allow the user to turn the units on and off, and to adjust temperature and fan speeds for one's comfort.

During the initial tour of the long-term care home (LTCH) and throughout this inspection, incremental cooling units, specifically the air outlets were observed to be heavily soiled with dust and debris in identified resident lounges and dining room, as well as nine resident bedrooms. The observed incremental units had no control switches, and the units were confirmed to be in 'off' mode by a Personal Support Worker (PSW) and maintenance staff. Observations identified a resident used a handheld paper punch to turn on the incremental cooling unit in their room and staff had been using nail clippers and forks to turn units on for residents and their comfort.

Concerns regarding the incremental cooling units being dirty and having no thermostat control switches were addressed with the Senior Director of Care (SR DOC) following the initial tour of the home and again, six days later, with the Environmental Services Manager (ESM). Both confirmed the home was fully air conditioned, and that each resident bedroom, lounge and dining room had their own incremental cooling for resident and others use. The SR DOC indicated the incremental units were being cleaned the day the inspection began.

Fifteen days following the start of the inspection, observed incremental cooling units remained dirty. Cooling units in two resident lounges, and seven resident bedrooms were observed to be in the 'off' mode. Approximately, fifty (50) incremental cooling units were without thermostat control switches preventing residents and others from operating them.

Maintenance staff indicated being unaware that the incremental units in resident bedrooms, lounges and dining rooms were dirty, and indicated being unaware that the incremental cooling units were to be in good working order by May 15th. Maintenance staff indicated that units had been without thermostat control switches for years. Air Temperatures in two resident lounges and in randomly selected resident bedrooms on a resident unit were taken and recorded, by maintenance staff and the Inspector, to be above 26 degrees Celsius.

On June 1, 2023, the temperature listed by Environment and Climate Change Canada was 30 degrees Celsius in Peterborough, Ontario.

Failure to ensure the air conditioning units were in proper working order, specifically cleaned and having thermostat control switches to operate them, placed residents at extreme risk for infection and heat related illness.

**Sources**: Observations of incremental units; recording of air temperatures in randomly selected resident lounges and bedrooms; interviews staff and management. [000722]

**This order must be complied with by** October 31, 2023

## COMPLIANCE ORDER CO #008 Infection prevention and control program

**NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee is ordered to comply with the following:

1. The IPAC Lead must ensure the outcome of all IPAC audits and evaluations are reviewed with departmental managers at the Manager's Daily Meeting, as well, at IPAC Committee Meetings; and a correction action plan, for any observed or noted deficiencies captured during IPAC audits and reviews, must be documented as to measures taken or to be taken, dates for follow-up and by whom. Documentation must be captured in the Managers Daily Meeting and IPAC Committee Meeting minutes. The Director of Care or their designate will oversee that IPAC audits, evaluations have been completed and that correction action is taken as required.

2. A process must be immediately developed and implemented for the labelling of personal care items and designated resident care equipment This process is to be communicated to all nursing staff. The process must include who is responsible for the labelling of personal care items and designated resident care equipment, on admission, and throughout the resident residency in the long-term care home. An audit will be conducted by the Director of Care or their designate weekly for 6 weeks, then monthly thereafter to ensure all personal care items and resident care equipment are labeled with the resident's name; and that personal care items and designated care equipment is stored in a sanitary manner. The audits and any corrective action taken will be documented and kept for Inspector's review.

3. A process must be immediately implemented to ensure that a designated staff has been assigned, on all shifts, to ensure that the personal protective equipment (PPE) is readily available in isolation caddies outside of resident rooms, for those residents identified as being under IPAC precautions. The

designated staff will be responsible for replenishing PPE supplies at the beginning of their shift, throughout the day and prior to their shift ending and will document that this task is completed. Any deficiencies will be documented along with the action taken. The IPAC Lead will be responsible to audit isolation caddies in use when they are in the home, on days the IPAC Lead is off, they will assign the audits to a designated person; the audits of isolation caddies will commence immediately upon receipt of this order, and continued daily for 2 weeks, then weekly for 4 weeks. The Director of Care or their designate will be responsible to ensure a process has been developed, implemented and a designated person be assigned to stocking and replenishing of PPEs outside of resident rooms doors, for those under precautions.

4. The importance of Hand Hygiene, following but not limited to the ‘4 Moments of Hand Hygiene’ is to be communicated to all staff and managers. The communication, including date communicated is to be maintained for review by the Inspector.

5. Hand Hygiene audits are to be conducted daily, on an identified resident unit, to ensure staff are performing hand hygiene as per the licensee’s policy. The audits will be conducted by the IPAC Lead daily for 4 weeks; any deficiencies observed will be addressed on the spot with staff. Documentation of hand hygiene audits will include date, time, staff observed, staff auditing, and any corrective action required. Documentation is to be kept for review by the Inspector.

6. Personal Support Workers #110, registered nursing staff #152, HSK #134 and Maintenance #128 are to be retrained on the licensee’s policy ‘Hand Hygiene’, the ‘4 Moments of Hand Hygiene’ and appropriate glove use. This re-training is to be documented, including staff name, date retrained and by whom; documentation is to be kept for review by the Inspector.

7. Communication, to all nursing and others involved with meal and snack service, as to the importance of resident hand hygiene as an integral part of the IPAC program. The communication, including the date, will be kept for review by the Inspector.

8. Resident hand hygiene audits are to be conducted before and after all meal service, on an identified unit, daily for 2 weeks, then twice weekly for 4 weeks. Audits are to be documented with any corrective action addressed at the time of the audit. Documentation is to be kept for review by the Inspector.

**Grounds**
1.The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with.

In accordance with the ‘Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes,

April 2022', IPAC Standard, section 2.3 directs, the licensee shall ensure the IPAC Lead, in collaboration with the interdisciplinary IPAC team, implements required improvements to address any evaluation and/or audit findings as well as recommendations arising from the quality program for IPAC.

**Summary and Rationale:**

During the inspection, areas of concern were identified, specifically regarding the accessibility of personal protective equipment (PPE) outside of resident bedrooms for those residents assessed as requiring additional IPAC precautions, labelling of personal care items and the cleaning and disinfection of resident care items.

Corporate IPAC Consultant, for Extendicare Canada indicated concerns, observed by the Inspector, had been previously identified and communicated to the IPAC Lead as areas needing improvement prior to the inspection. Corporate IPAC Consultant indicated a plan should have been in place to address audit findings.

IPAC Lead, for the long-term care home, confirmed being aware of inaccessibility of PPE outside of resident rooms, specifically those on IPAC precautions, unlabeled personal care items, and cleanliness of washbasins, bedpans, and urinals. IPAC Lead indicated concerns had been discussed at the last IPAC meeting, and further indicated that no action had been taken to address the concerns as of this time.

Failure to address IPAC audits and evaluation findings delays the development and implementation of corrective action plans to resolve deficiencies in the IPAC program, and places residents and others at risk of infections.

**Sources:** Observations of IPAC practices and procedures during the inspection; interview with staff and management. [000722]

2. The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022". IPAC Standard, section 5.4 (k) directs the licensee shall ensure that policies and procedures for the IPAC program address, policies for cleaning and disinfecting. Standard 5.5, directs, the licensee shall identify how IPAC policies and procedures will be implemented in the home.

**Rationale and Summary:**

A licensee policy, Personal Care Equipment: Cleaning and Disinfecting states that staff must properly clean and disinfect all dedicated and non-dedicated resident personal care equipment after each use to prevent the spread of infections. The policy directs, dedicated washbasins, urinals and bedpans are to be labelled with the resident's name and stored in a clean and sanitary manner in the resident's bedroom; non-dedicated clean and disinfected resident care equipment is to be stored in the clean utility room.

Another licensee policy, Resident Care Equipment directs that care staff will clean and disinfect all resident care equipment in accordance with manufacturer's instructions and IPAC Best Practice Guidelines (i.e., commodes, bedpans, urinals, etc.) after each use and store these items in the location designated by home-specific procedures.

During the initial tour of the long-term care home (LTCH) and subsequent observations, unlabeled bedpans, urinals and washbasins were observed on the floors in shared washrooms.

A Personal Support Worker (PSW) indicated that washbasins, bedpans, and urinals were to be cleaned and disinfected following individual resident use. PSW and a Housekeeping Staff (HSK) indicated resident washbasins, bedpans and urinals were not to be placed on washroom floors for sanitary reasons. PSW indicated the placement of washbasins, bedpans and urinals on the floor has been a normal practice by staff, as there is limited space in resident bedside tables.

IPAC Lead indicated washbasins, bedpans and urinals are dedicated for individual resident use and are to be cleaned and disinfected following use and stored in designated areas in resident's bedroom and/or in utility rooms. IPAC Lead and the Corporate IPAC Consultant confirmed that resident care equipment is to be individually labelled. The IPAC Lead indicated resident care equipment is not to be placed on floors but indicated being aware that this such is a problem within the home.

Improper labeling, cleaning, disinfection, and storage of resident care equipment places residents at risk for infections.

**Sources:** Observations throughout the inspection; review of licensee policies, Resident Care Equipment, and Personal Care Equipment: Cleaning and Disinfecting; and interviews with staff and management. [000722]

3. The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022". IPAC Standard, section 6.1, the licensee shall make personal protective equipment (PPE)

available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care, which may be in place.

**Rationale and Summary:**

During the initial tour of the long-term care home (LTCH), infection prevention and control (IPAC) signage were observed outside of two resident bedrooms doors identifying residents as being under IPAC precautions. The required personal protective equipment (PPE) was not observed available for staff and others to access outside of these resident rooms.

The clinical health record was reviewed and verified the residents had been assessed and were under IPAC precautions.

Two Personal Support Workers (PSW) confirmed that staff were to wear PPE while caring for the two residents. Both PSWs indicated that there was no unit staff specifically assigned to ensuring PPEs were available for use.

Infection Prevention and Control Lead (IPAC-Lead), as well at the Corporate IPAC Consultant indicated that PPE supplies should be available for use outside of bedroom doors for anyone under additional precautions. IPAC Lead indicated the restocking of PPE has not been assigned to anyone specifically, which has led to issues of availability of PPE at point of care.

Failing to ensure the proper PPE supply were available for staff when caring for residents, that require additional precautions, places residents at risk harm due transmission of infections.

**Sources:** Observations during initial tour of the LTCH; clinical record review for two identified residents; interviews with staff and management. [000722]

4. The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with.

In accordance with the “Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022”. IPAC Standard, sections 9.1 (b) and 9.1 (d), the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, specifically, at minimum Routine Practices shall include, hand hygiene, including but not limited to, at the four moments of hand hygiene, before

and after resident/resident environment contact; and the proper use of PPE, including application, selection and removal.

**Rationale and Summary:**

During the initial tour of the home the following observations were observed:
- Housekeeping Aid (HSK) #134 was observed exiting a resident bedroom with gloves on their hands, moving the housekeeping cart and entering another resident's room wearing the same gloves; HSK was not observed to remove their gloves, nor perform hand hygiene. A resident in an identified room was under IPAC precautions.
- A registered nursing staff #152 was observed exiting a resident bedroom without performing hand hygiene, walked down the hallway to a nursing supply cart, donned gloves and walked back down the hallway and into a resident's room. The nurse was not observed to perform hand hygiene.

The next day, Personal Support Worker (PSW) #110 and another PSW in training entered an identified resident bedroom without performing hand hygiene. PSW #110 was observed exiting an identified resident bedroom and entering another resident bedroom without performing hand hygiene. That same day, Maintenance staff #128 was observed exiting a resident's room wearing gloves, walking to the nursing station to answer a phone call, exiting the nursing station, walking to the elevator, and pushing the elevator button, then entering the elevator with the gloves still on their hands. Maintenance Staff was not observed to remove their gloves nor perform hand hygiene.

Internal training records were reviewed and identified HSK #134, PSW #110, registered nursing staff #152 and maintenance staff #128 had received IPAC training, specifically hand hygiene, in 2022.

Infection Prevention and Control Lead (IPAC-Lead) and the Corporate IPAC Consultant, for Extendicare, indicated that the home follows the 'Four Moments' which includes performing hand hygiene before and after exiting a resident's environment. Both indicated staff were expected to remove gloves while exiting a resident's bedroom and perform hand hygiene following.

Failure of staff to perform hand hygiene before and after resident care; and to appropriately use and dispose of gloves places residents at risk for infections.

**Sources:** Observations during the inspection; review of internal training records for identified staff; interviews with staff and management. [000722]

5. The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022". IPAC Standard, section 10.4 (h), the Licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program including, support for residents to perform hand hygiene prior to receiving meals and snacks.

**Rationale and Summary:**

The licensee's policy, Hand Hygiene, directs residents will be encouraged and/or offered assistance to properly wash or sanitize their hands regularly, including before and after meal service.

During five separate meal service observations, residents were observed being brought into a unit dining room and provided their meal without staff assisting or encouraging residents to perform hand hygiene. Staff assistance and/or encouragement with resident hand hygiene following meal service was not observed during throughout the inspection.

Personal Support Workers (PSW) indicated staff are to assist residents in performing hand hygiene prior to and following meal service.

Infection Prevention and Control (IPAC) Lead indicated staff encouragement and assistance with resident hand hygiene before and after meal services is an area of needed improvement.

Failing to assist or encourage residents to perform hand hygiene prior to and following meal service increases the risk of infections to residents and others.

**Sources:** Observations prior to and following meal service; review of licensee policy 'Hand Hygiene'; and interviews with staff and management. [000722]

**This order must be complied with by** October 31, 2023

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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