Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: December 8, 2023

Inspection Number: 2023-1088-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Peterborough, Peterborough

Lead Inspector	**Inspector Digital Signature**
Patricia Mata (571)	Patricia Mata Digitally signed by Patricia Mata Date: 2023.12.12 11:01:06 -05'00'

Additional Inspector(s)
Catherine Ochnik (704957)
Chantal Lafreniere (194)
Sami Jarour (570)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-10, 14-17, and 20-22, 2023, and off-site on November 23, 2023.

The following intake(s) were inspected:
· Intake: #00001693 related to equipment malfunction.
· Intake: #00006486 related to improper transfer of a resident
· Intake: #00012005 and #00089546 related to allegation of staff to resident neglect.
· Intake: #00088060 related to allegation of resident-to-resident physical

abuse.
· Intake: #00097993, related to a complaint for an allegation of resident-to-resident abuse
· Intake: #00088886 related to a complaint for allegations of improper care

NOTE: Regarding intake #00088886 related to a complaint for allegations of improper care: a Written Notification related to FLTCA, 2021, s. 28 (1) 1, O. Reg 246/22, s. 57 (1) 4 and O. Reg 246/22 s. 108 was identified in this inspection and has been issued in a concurrent inspection, #2023_1088_0003, dated December 8 , 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #004 from Inspection #2023-1088-0001 related to O. Reg. 246/22, s. 23 (4) (a) inspected by Patricia Mata (571)

Order #008 from Inspection #2023-1088-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Chantal Lafreniere (194)

Order #007 from Inspection #2023-1088-0001 related to O. Reg. 246/22, s. 23.1 (3) inspected by Patricia Mata (571)

Order #003 from Inspection #2023-1088-0001 related to FLTCA, 2021, s. 19 (2) (c) inspected by Patricia Mata (571)

Order #002 from Inspection #2023-1088-0001 related to FLTCA, 2021, s. 6 (10) (c) inspected by Sami Jarour (570)

Order #001 from Inspection #2023-1088-0001 related to FLTCA, 2021, s. 3 (1) 23. inspected by Sami Jarour (570)

Order #005 from Inspection #2023-1088-0001 related to O. Reg. 246/22, s. 77 (5) inspected by Catherine Ochnik (704957)

Order #006 from Inspection #2023-1088-0001 related to O. Reg. 246/22, s. 79 (1) 5. inspected by Catherine Ochnik (704957)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36
Transferring and positioning techniques
s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #010 on February 22, 2022.
On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director to report a transfer that resulted in an injury to a resident.

The plan of care for the resident indicated that the resident was a two staff assist with transferring.

A Personal Support Worker (PSW) confirmed they transferred the resident without assistance. The PSW and Registered Nurse (RN) indicated the resident was injured after the transfer.

When staff did not ensure safe transferring techniques were used, this resulted in an injury to a resident.

Sources: CIR, licensee's internal investigation, resident #010 clinical health records and interview with staff (PSW#113 and RN #114). [194]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure an allegation of resident-to-resident abuse that caused harm or a risk of harm to the resident was reported to the Director.

Rationale and Summary:

A complaint regarding an incident of alleged abuse between two residents was submitted to the Director. A CIR regarding the same incident was submitted to the Director two days later.

In an interview, the Director of Care (DOC) confirmed that the suspected abuse was reported to the Director two days after the incident occurred.

Failing to ensure that an allegation of abuse was reported immediately to the Director may put residents at risk for further abuse.

Sources: CIR, resident progress notes, and interview with the DOC. [704957]

2. The licensee has failed to ensure an allegation of resident-to-resident abuse that caused harm or a risk of harm to the resident was reported to the Director.

Rationale and Summary:

A CIR was submitted to the Director for an allegation of resident-to-resident physical abuse one day after the incident.

During an interview with the acting Director of Care for Quality (DOCQ), it was acknowledged that the incident required immediate reporting to the Director and was not immediately reported.

Failing to ensure that an allegation of abuse was reported immediately to the Director may put residents at risk for further abuse.

Sources: CIR, and interview with the acting DOCQ. [570]

WRITTEN NOTIFICATION: Initial plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 28 (1) (a)
Initial plan of care
s. 28 (1) Every licensee of a long-term care home shall ensure that,

(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and

The licensee failed to ensure that a pain assessment that was necessary to develop a resident's plan of care specific to pain management was completed.

Rationale and Summary:

A complaint was submitted to the Director regarding poor pain control for a resident.

A pain assessment was not completed within 14 days of the resident's admission, which was necessary to develop an initial plan of care. The resident's plan of care before and after the 14-day period did not include goals, interventions, and clear direction to staff related to management of pain.

The DOC indicated a pain assessment should have been done upon admission.

By failing to complete an initial pain assessment, the resident's plan of care lacked goals, interventions and clear direction related to the management of pain which put the resident at risk for poor pain management.

Sources: resident clinical health records, interview with the DOC. [571]

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A complaint was submitted to the Director concerning poor pain management for a resident.

The Registered Practical Nurse (RPN) did not did not use a clinically appropriate assessment instrument when reassessing a resident after the resident was administered analgesic and self reported that it was not effective. There was no evidence that other pain interventions where implemented.

The Director of Care (DOC) indicated staff should assess residents using the licensee's pain assessment tool when residents' pain has not been relieved by the initial intervention. The licensee's tool is a clinically appropriate assessment instrument.

Failure to use a clinically appropriate assessment instrument when the resident indicated their pain had worsened, prevented staff from understanding the full scope of the resident's pain so that appropriate interventions could be implemented.

Sources: Resident clinical health records, interview with the DOC and the licensee's pain policy. [571]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that on every shift symptom indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director.

IPAC standard 3.1 (i) directs the licensee to ensure that the following surveillance actions are taken: Employing syndromic surveillance regularly to monitor for symptoms, including but not limited to, fever new coughs, nausea, vomiting, and diarrhea, and taking appropriate action.

Rationale and Summary:

The IPAC lead confirmed that the registered staff were to complete an assessment utilizing a Daily 24-hour symptoms surveillance form, for residents that were identified with symptoms of infection on every shift. The IPAC lead also indicated that some staff were documenting the assessment of symptoms in the progress notes. They indicated that they would review all progress notes daily for any symptoms of infection, they also attended the Daily management meeting, along

with the Registered Nurse (RN)s in the home who would update management of any infection control situations in the home.

An outbreak was declared in the home. A review of clinical health records and symptom surveillance forms of three symptomatic residents indicated that symptom tracking for three residents was not done on every shift.

An RPN and RN indicated that they were to assess and document symptoms of infection in residents. The RN confirmed that the three residents were not included on the symptom surveillance form for an entire 24-hour period.

Failing to ensure that on every shift symptoms indicating the presence of infection in residents were monitored placed the home at increased risk of infection.

Sources: Review of the outbreak line listing, symptoms surveillance forms, clinical health records of resident, Infection Surveillance Policy and interview with staff. (IPAC lead, RPN #120, RN #114). [194]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of a COVID-19 outbreak.

Rationale and Summary:

A COVID-19 outbreak was declared in the home. A CIR was submitted to the Director to report the COVID-19 outbreak.

A review of clinical health records indicated two residents tested positive for COVID-19 with a Rapid Antigen Test (RAT) two days prior to outbreak being declared and reported.

The IPAC lead was aware of one resident testing positive for COVID-19 and indicated that with only one resident testing positive with a RAT, the home did not need to notify Public Health unit to report the outbreak.

The Public Health Nurse (PHN) confirmed that the home would have been in an outbreak situation and should have reported, if two residents tested positive for COVID-19 with RAT.

Failing to ensure that the Director is immediately informed of an outbreak, places the residents and community at risk.

Sources: Review of the progress notes for the identified residents and interview with staff and Public Health and IPAC lead. [194]