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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: August 28, 2024	
Inspection Number: 2024-1088-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Peterborough, Peterborough	
Lead Inspector The Inspector	**Inspector Digital Signature** Rita Lajoie Digitally signed by Rita Lajoie Date: 2024.09.10 15:35:26 -04'00'
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6, 7, 8, 9, 13, 14, 15, 16, 2024
The inspection occurred offsite on the following date(s): August 8, 12, 2024

The following intake(s) were inspected:

- Intake: #00122221
- Proactive Compliance Inspection - PCI

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

Skin and Wound Prevention and Management
Resident Care and Support Services

Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, the plan of care reviewed and at any other time when,(b) the resident's care needs changed.

Rationale and Summary:
As part of the PCI, it was identified that a resident received a palliative status on a specific date, and began the initiation of subcutaneous medication for pain.

The home's Palliative Care Program identified that the Nurse develop a plan of care that support pain and symptom management strategies.

A record review indicated that the resident's care plan was not updated to reflect the change to palliative status and a pain focus.

Interviews with the Clinical Coordinator and Pain and Palliative Lead confirmed the date the resident became palliative, and began to receive subcutaneous injection of medication and the care plan was not updated and should have been.

Failure to revise the plan of care when the resident's care needs changed, resulted in a potential for incorrect care by the care team.

Sources: Palliative Care Program , resident #012's health records and plan of care, Interviews with the Clinical Coordinator and RN.

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that two Housekeepers who have received training under subsection (2) receive retraining in Infection Prevention and Control mentioned at times or at intervals provided for in the regulations.

Rationale and Summary:
As part of the PCI assessment, the internal IPAC program within the home was reviewed and two members of the housekeeping staff were interviewed.

Housekeeper #101 had their Infection Prevention and control annual modules due on a specified date, and did not complete the modules.
Housekeeper #103 had their Infection Prevention and control annual modules due on a specified date and completed the modules late.

An Interview with the Environmental Services Manager confirmed that all staff are expected to complete the IPAC training by the required date. The ESM also confirmed that they receive a list of staff members who have their modules due and had spoken in person to both housekeepers. An interview with the Director of Care (DOC) confirmed the expectation in the home is for all staff to complete the learning modules for annual retraining by the required due date.

Failure of the Housekeepers to complete IPAC modules may have placed the residents at an increased risk for the possible spread of infections, due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Housekeeper Training records, Interview with ESM and DOC.

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the

home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in at least two resident bedrooms in different parts of the home, in one resident common area on each floor of the home and in every designated cooling area at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary:
As part of the PCI, assessment is conducted to ensure the home is maintaining a minimum temperature of 22 degrees and that temperature record logs have been completed as per O. Reg. 246/22, s. 24 (2).

The ESM indicated that they take temperatures manually in a resident room and a common area but not in the cooling centres. The ESM indicated that during the evening / night shift a registered nurse is assigned to take and record the temperatures.

A review of the temperature logs for three months in 2024 indicated that temperatures were not consistently taken in two different resident rooms, in one resident common area on each floor and in designated cooling areas. Times that the temperatures were taken were not recorded consistently and data was missing for several days.

Failure to monitor the temperature consistently in the designated areas may have

limited the licensee's ability to ensure that temperatures were being maintained at the level required.

Sources: daily air temperature logs, interview with Environmental Services Manager

WRITTEN NOTIFICATION: Air temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature was measured and documented in at least two resident bedrooms in different parts of the home, in one resident common area on each floor of the home and in every designated cooling area at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary:
As part of the PCI, assessment is conducted to ensure the home is maintaining a minimum temperature of 22 degrees and that temperature record logs have been completed as per O. Reg. 246/22, s. 24 (2).

The ESM indicated that during the evening / night shift a registered nurse is assigned to manually take and record air temperatures.

A review of the temperature logs for three months in 2024 indicated that temperatures were not consistently taken in two different resident rooms, in one resident common area on each floor and in designated cooling areas three times daily.

A review of data recorded in the Common Area Temperature records for July and August, 2024 indicated that that there no recordings for the temperatures in two resident rooms in different home areas, one resident common area on each floor of the home and in designated cooling areas during the evening / night shift

Failure to monitor the temperature consistently in the areas required may have limited the licensee's ability to ensure that temperatures were being maintained at the level required.

Sources: Daily Air Temperature logs, Common Area Temperature records, interview with Environmental Services Manager

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that resident #013 received a skin and wound assessment upon return from hospital.

Rationale and Summary
As part of the PCI, assessment was conducted to ensure the home is providing skin and wound care as per legislated requirements. Record reviews for skin and wound assessments and dressing changes were completed for two residents.

Review of a resident's progress notes indicated that they were admitted to hospital on a specific date and returned on a specific date. Progress notes for a specific day and time indicate the bandage is dry and intact. Has been changed at the hospital and will update eTAR.

Review of the home's Skin and Wound Program: Prevention of Skin Breakdown indicated that a head-to-toe assessment is to be completed upon any return from hospital.

The Clinical Coordinator indicated that wounds are to assessed upon any return of the resident from hospital.

Failure to complete a skin and wound assessment upon return from hospital put the resident at risk of receiving inadequate or inappropriate wound treatment.

Sources: resident #013 clinical records, eTAR, home's Skin and Wound Program: Prevention of Skin Breakdown ， Interview with Clinical Coordinator

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident was provided with wound care at the frequency ordered.

Rationale and Summary:
As part of the PCI, assessment was conducted to ensure the home is providing skin and wound care as per legislated requirements. Record reviews for skin and wound assessments and dressing changes were completed for two residents.

An RN indicated that it is the expectation that wound dressings are completed as ordered and signed off in the electronic Treatment Administration Record (eTAR) to show that it has been done

Review of a resident's clinical records indicated that a dressing to a specific site was to be completed every two days. eTAR entries indicated the wound dressing was documented as dry and intact (D&I) on three specific dates, no documentation for two specific dates. Further reviewed revealed that dressing changes to the specified site were not completed as ordered on a number of occasions.

Failure to provide a resident with dressing changes to their wound at the frequency ordered potentially compromised wound healing.

Sources: resident clinical records, eTAR, Interview with RN

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that resident #013 received wound assessments weekly using a clinically appropriate assessment instrument.

Rationale and Summary
As part of the PCI, assessment was conducted to ensure the home is providing skin and wound care as per legislated requirements. Record reviews for skin and wound assessments and dressing changes were completed for two residents.

The Clinical Coordinator indicated the expectation is that wounds are to be assessed weekly with the use of a clinically appropriate assessment instrument

Review of the home's Skin and Wound Program: Wound Care Management indicated that resident skin condition is to be monitored with each dressing change and reassessed at minimum every seven days.

Failure to complete weekly skin and wound assessments put the resident at risk of receiving inadequate or inappropriate wound treatment.

Sources: resident clinical records, eTAR, home's Skin and Wound Program: Wound Care Management . Interview with Clinical Coordinator

WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that monitoring of a resident's responses to, and the effectiveness of, the pain management strategies.

Rationale and Summary:
As part of the PCI, it was identified that a resident received a palliative status on a specific and began the initiation of subcutaneous medication for pain.

The home's Pain Identification and Management Policy indicated that when a resident has a new pain or new pain related medication, the resident is assessed using the comprehensive pain assessment which includes the severity, location, quality and radiation. This should be completed on day, evening shift, and nights when awake for seventy-two hours.

A record review indicated that when resident became palliative on a specific date and began to receive subcutaneous injection of medication, that no comprehensive pain assessment was conducted on days, evenings and if awake on nights for seventy-two hours.

Interviews with the Clinical Coordinator and Pain and Palliative Lead RN confirmed that the resident became palliative on a specific date and began to receive subcutaneous injection of medication, comprehensive pain assessments were not done as required and should have been.

Failure to complete a comprehensive pain assessment for the resident for seventy two hours as required, resulted in no awareness that the pain medication was effective.

Sources: Pain Identification and Management Policy , residents electronic health record, interviews with Clinical Coordinator and RN.

WRITTEN NOTIFICATION: Housekeeping

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures are developed and implemented for, cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Rationale and Summary:
During the PCI inspection, as part of the IPAC assessment, two pieces of resident care equipment was observed. A Sit-to-Stand Lift was in the hallway on Lilac Lane, with a residents' labelled sling laid across the lift.

As per the Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Environmental Cleaning for Prevention and Control of Infections, hydraulic lift slings are to be laundered in between patients and when soiled, and dedicated to an resident if possible.

An interview with a PSW confirmed that the residents' labelled sling should be in the

residents room, and not across the lift in the hallway. The resident does not require the use of the labelled identified sling any longer, and that sling was used on another resident who did not have a dedicated personal sling. The PSW identified that slings were not available and that they would have to go to another until, to a storage closet, to see if a sling was available, but they were too busy to do so.

An interview with the Director of Care (DOC), confirmed that the home does have extra slings for residents who require their use and that the home audits slings monthly for residents to ensure every resident has their own sling, which is kept in the residents room on the back of the residents entrance door. The DOC also confirmed that slings are not to be borrowed from another residents room without that sling being laundered and relabeled.

By not ensuring procedures were implemented regarding cleaning and disinfection practices for hydraulic lift slings, there was a potential risk for the spread of infectious agents amongst residents.

Sources: Observations, Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings. 3rd ed. , interviews with PSW and DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, related to Waste Management under section 5.4 (e) of the IPAC Standard.

The licensee has failed to ensure that policies and procedures for the IPAC program also address: waste management.

Rationale and Summary:
During the PCI Inspection of medication storage, the government medication stock room which contains medications, gloves, dressing supplies was inspected. It was observed that the door to the room, had a sign indicating "Biohazardous Waste" and inside the room was a box, lined with a yellow plastic bag with closed, full sharps containers.

The homes' policy on Biohazardous Waste indicated that collection and storage of biohazardous waste in approved biohazardous waste containers and ensure the final storage is separate from the clean supply rooms and food storage/preparation areas.

An interview with the DOC was not aware that the biohazardous waste should not be stored in the government medication stock room as this has been the location of the biohazardous waste for several years.

Failure to follow the biohazardous waste policy placed the contents of the government medication stock room at risk of contamination.

Sources: IPAC Standard for Long -Term Care Homes Revised September 2023.,Biohazardous Waste policy , observations, interview with the DOC.

COMPLIANCE ORDER CO #001 Compliance with manufacturers' instructions

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) A supply of AHP 1750 Testing Containers and Strips is to be made available in every housekeeping closet throughout the home and on every housekeeping cart.
2) The IPAC Lead will educate the ESM, and all Housekeeping Staff on the proper procedures for testing of the Oxivir Plus Disinfectant Cleaner, interpretation, and completing the AHP 1750 test strip testing results sheets.
3) Audit on Days and Evenings the use of the Testing Strips and The Testing Tracking Sheets for four weeks, by the ESM.
4) Keep a documented record of the audits completed, along with the name of the person who completed the audit, the date the audit was performed, include any corrective action taken and make available for Inspectors immediately upon request.

Grounds
The licensee has failed to ensure that Housekeeping staff use all equipment,

supplies, in the home in accordance with manufacturers' instructions.

Rationale and Summary:
During a PCI, a Diversey disinfectant wall unit was observed in the housekeeping closet which was being used by the home to dilute and dispense the Oxivir Plus Disinfectant and Cleaner used for cleaning and disinfection of contact surfaces in resident areas.

During an interview with a Housekeeper, they confirmed that housekeeping staff were expected to test the concentration of the Oxivir Plus Disinfectant and Cleaner dispensed from the wall unit weekly, and when the new concentrate bottle is replaced, and record the readings on the AHP 1750 test strip testing results sheet. A Housekeeper had an AHP 1750 testing strip container with testing strips in the housekeeping closet which had an expiry date of 03-14-2024. The AHP 1750 test strip testing results sheet identified the last recorded reading of the home's disinfectant concentration levels was May 26, 2024.

During an interview with a Housekeeper they confirmed they were not aware of any chemical strip testing and did not know where the recorded testing results sheet was located, despite being part time in the housekeeping role for a specific number of years. Inspector located the chemical testing strips and the strip testing results sheet in a clear plastic folder hanging from the tap in the janitors closet. A Housekeeper had an AHP 1750 testing strip container with testing strips in the housekeeping closet which had an expiry date of 03-14-2024. The AHP 1750 test strip testing results sheet identified the last recorded reading of the home's disinfectant concentration levels was July 15, 2024.

In an interview the Environmental Services Manager (ESM), indicated that they were not aware of the incomplete AHP 1750 test strip testing results sheets in two areas

of the home, and confirmed that they should be completed as directed on the AHP 1750 test strip testing results sheet to test the concentration of the Oxivir Plus Disinfectant and Cleaner dispensed from the wall unit weekly, and when the new concentrate bottle is replaced, and record the readings on the AHP 1750 test strip testing results sheet., The ESM confirmed that the staff were using an expired testing strip container, but the strips were not expired. The ESM was not aware that a Housekeeper did not know how to test the chemicals using the chemical testing strips and record the results on AHP 1750 test strip testing results sheet.

By failing to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions, the licensee increased the risk for health care associated infections.

Sources: Oxivir Plus Disinfectant dispenser equipment observation, AHP 1750 test strip testing results sheet, Diversey Plus Information Sheets, AHP 1750 information sheets interview with ESM and Housekeepers

This order must be complied with by October 2, 2024

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

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.