Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 24, 2021 | 2021_640601_0006 | 025525-20, 000197-21 | Critical Incident System |

### Licensee/Titulaire de permis

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

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

Extendicare Port Hope
360 Croft Street Port Hope ON  L1A 4K8

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

KARYN WOOD (601)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): March 2, 3, 4, and 5, 2021.**

**The following intakes were completed in this Critical Incident System (CIS) Inspection:**

**A log related to allegations of staff to resident neglect.**

**A log related to a fall that resulted in a change in condition.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, Acting Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and a resident.**

**The inspector also reviewed resident health care records, infection control practices in the home, policies, observed the delivery of resident care and services, including staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff involved in the resident's care collaborated with each other regarding the resident’s assessment so that their assessments were integrated, consistent and complemented each other when the resident was not accepting staff attempts to provide personal care, meals, and medication.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report regarding allegations of staff to resident neglect.

The PSWs attempted to awaken the resident before and after breakfast and the resident declined personal care both times. The resident refused their scheduled medications. The RPN reported to RN #112 near the end of their shift that the resident had not eaten or taken their medication. The RN assessed the resident when the resident’s SDM arrived fifteen minutes before the shift ended and found the resident had a significant change in condition. The physician was immediately notified by RN #119, and the resident received a treatment with good effect.

The RPN indicated they should have collaborated with each other when the resident was difficult to awaken and was not accepting staff attempts to provide personal care, meals and medication.

The internal investigation determined the communication amongst staff at beginning of the shift did not specify the PSW who would be providing the resident’s personal care. The DOC indicated the staff working had identified the resident was having an off day, but did not recognize the severity and should have communicated with each other.

The resident was at risk for impaired mobility, and dehydration when staff did not collaborate with each other when they were not able to wake the resident to provide personal care, administer medication and that the resident had not taken any food or fluids during a shift.

Sources: The resident’s care plan and progress notes, internal investigation notes, and interviews with the PSW, RPN, and the DOC. [s. 6. (4) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program related to the use of Personal Protective Equipment (PPE).

PSWs were observed exiting two resident rooms that required droplet and contact precautions, as per the signage on the bedroom door. The PSWs were observed to be within two meters of the residents, and they did not change their mask and face shield when leaving these resident rooms.

The long-term care home's IPAC program included the requirement for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident on contact and droplet precautions. The home's guidelines for residents who were on isolation related to the "COVID-19 Universal PPE Guidelines", Appendix one directed staff to continue to wear mask and eye protection after each interaction with a resident when wearing a face shield, unless otherwise directed by the local health authority.

Public Health Ontario, "Universal Mask Use in Health Care Settings and Retirement Homes" directed for staff to change their mask and eye protection when leaving a

resident's room that was on droplet and contact precautions when direct care was provided within two meters of a resident.

PSWs, Acting Assistant Director of Care (ADOC) and the Director of Care (DOC) indicated staff were not required to remove their mask and face shield when leaving a resident's room that was on droplet and contact precautions. They further indicated the education provided to staff was to wear the same mask throughout their shift unless it becomes visibly soiled or wet, and to clean their face shield when visibly soiled. The DOC indicated that staff received a mask and a clean face shield at the beginning of their shift, and the face shield would be cleaned at the end of the shift when staff exited the home.

The DOC indicated the licensee had COVID-19 universal PPE guidelines in place to conserve PPE, and they were not aware that Public Health Ontario, "Universal Mask Use in Health Care Settings and Retirement Homes" directed for staff to change their mask and eye protection when leaving a resident's room that was on droplet and contact precautions.

Staff failed to participate in the implementation of the IPAC program which presented actual risk of infection to residents.

Sources: Observation of signage two resident bedroom doors. The Public Health Ontario's, "Universal Mask Use in Health Care Settings and Retirement Homes", the licensee's "COVID-19 Universal PPE Guidelines", PSW interviews and observations , and interviews with the Acting ADOC, and DOC. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that all staff participate in the implementation of the program, to be implemented voluntarily.***

**Issued on this 14th day of April, 2021**

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

**Original report signed by the inspector.**