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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 23, 2021	2021_946111_0001	005637-21, 006199-21, 007514-21, 009793-21, 010168-21, 012553-21, 012696-21	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

LYNDA BROWN (111)

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): August 17 to 20, 23 to 26, 2021.

There were eight critical incidents and other mandatory inspections completed concurrently during this inspection:
-three critical incidents related to alleged resident to resident abuse.
-Three critical incidents related to falls with injury.
-Two critical incidents related to alleged staff to resident neglect.
-Infection Prevention and Control practices.
-Safe and Secure for Air Temperatures.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Associate Director of Care (acting ADOC), Quality Risk Management Coordinator, Environmental Services Manager, Maintenance, Housekeepers (HSK), Registered Nurses
(RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assistants (RAs), Physiotherapist, residents and families.

During the course of the inspection, the inspector: toured the home, observed meal services, observed continence supplies, reviewed investigations, resident health records, staffing records/schedules, complaints logs, air temperature logs, and reviewed the following policies- Zero Tolerance of Abuse and Neglect, Responsive Behaviours, Falls Prevention and Management Program, Preventing Heat-Related Illnesses and Complaints and Customer Services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

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

7 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care for resident #006 was provided to the resident related to hygiene, grooming and dressing.

The home received a written complaint from the family of resident #006, alleging neglect of care related to hygiene and grooming.The staff were to provide specified interventions related to hygiene and grooming. The home's investigation revealed that the resident frequently refused specified hygiene and additional interventions were to be implemented at those times. The investigation also revealed the resident had been inappropriately dressed on a specified date and time. The home implemented audits of the resident to ensure that hygiene, grooming and dressing was provided, and identified a number of dates when their hygiene and grooming had not been provided as per the plan of care.Observation by the Inspector on specified dates and times, revealed the resident had not been provided specified hygiene as per the plan of care. Failing to provide the resident with proper hygiene and grooming as per the plan, can lead to a loss of dignity.

Sources: observations, review of progress notes, point of care (POC), care plan, audits, investigation, and interviews with family and staff.

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 the plan of care is provided to the resident as indicated in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the complaints policy instituted or otherwise put in place was complied with, for resident #006.

An RPN received a verbal complaint from the family of resident #006 on a specified date, regarding care not being provided to the resident. Two days later, the family submitted a written complaint to the home for alleged staff to resident neglect. The complaint indicated the resident had been found on multiple dates with hygiene and grooming not completed and an incident of being dressed inappropriately. The home's investigation confirmed the RPN had received a verbal complaint from the family two days before the written complaint was received, the verbal complaint had not been resolved within 24 hours and the family had remained upset. The investigation verified the resident had been inappropriately dressed. The home's written response to the family did not indicate whether the allegation was determined to be founded or unfounded as per the home's complaint policy. The RPN did not complete the required documentation for the families concerns and the assessment of the resident in the resident's health record, as per the home's complaint policy. The investigation did not include steps that were required related to witnesses and contacts with the complainant as per the home's complaint policy. The conclusion of the investigation was not included to indicate whether the complaint was unfounded and the reasons why this conclusion was reached, as per the home's complaint policy. The corrective actions identified in the post investigation were not completed as indicated. There was also no indication of any corrective actions taken as appropriate, post-investigation as per the home's complaint policy, when the home confirmed that the resident had been inappropriately dressed. The former DOC (RN #101

) indicated the investigation was determined to be unfounded despite the complaint log indicating the complaint was determined as founded. Failure to comply with the home's complaint policy for allegation of staff to resident neglect for resident #006 may lead to further neglect of resident #006 and other residents.

Sources: observations, resident #006 care plan and progress notes, complaint logs, critical incident report (CIS), home's investigation, Complaints and Customer Service policy and interview of family and staff.

2. The licensee has failed to ensure that the complaints policy instituted or otherwise put in place was complied with, for resident #007.

The family of resident #007 had requested staff assistance to provide continence care to the resident, as the resident had been incontinent. The following day, the home received a written complaint from the family, alleging staff to resident neglect and the lack of continence care supplies. The family reported the staff provided improper continence care due to a lack of continence care supplies. The home's investigation revealed that staff had provided improper continence care to resident #007 due to lack of continence care supplies being available. The home's written response to the family indicated corrective actions included ensuring adequate supply of continence care supplies. The response did not indicate whether the allegation was determined to be founded or unfounded. The investigation did not include steps required as per the home's complaint policy. The written response at the conclusion of the investigation did not indicate whether the complaint was founded or unfounded, and the reasons why this conclusion was reached. The acting ADOC (RN #115) and Administrator both confirmed the investigation was determined to be unfounded, despite the complaint log indicating the complaint was determined as founded and the investigation confirming the resident had been provided improper care due to lack of continence care supplies. They both confirmed they had not utilized the appropriate investigation tools as per the home's complaint policy. Failure to comply with the home's complaint policy for allegation of staff to resident neglect may lead to further neglect of residents.

Sources: observations, resident #007 care plan and progress notes, complaint logs, critical incident report (CIS), home's investigation, Complaints and Customer Service policy, and interview of staff.

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 that the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, and (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (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. O. Reg. 79/10, s. 21 (3).

s. 21. (4) The licensee shall keep a record of the measurements documented under subsections (2) and (3) for at least one year. O. Reg. 79/10, s. 21 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperatures in the home were maintained at a minimum of 22 degrees Celsius.

The home was required to keep a documented record of air temperatures in cooling areas and two resident rooms (one on each floor). One of the resident rooms had a portable air conditioning unit. The home had air conditioning in three designated cooling areas on each unit (lounges, dining rooms and activity rooms). On a number of identified dates and locations, there were air temperatures below 22 degrees Celsius (C). The Environmental Services Manager (ESM) indicated there were electronic thermostats in each of the cooling areas and designated resident rooms. The ESM indicated the home switched to an electronic monitoring system on July 10, 2021 that monitored those thermostats and would send an alert to their phone and an email when the air temperatures were below 22 C. The ESM indicated they would then investigate the cause, notify maintenance to check air conditioning units or contact the HVAC company.

The ESM confirmed one sensor was not working in a specified unit and they were awaiting for the new sensor to arrive. The ESM indicated they had no documented evidence of actions taken to address the air temperatures below 22 C on the identified dates and locations.

Sources: air temperature logs and interview with staff. [s. 21.]

2. The licensee has failed to ensure that the temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Amendments to Ontario Regulation 79/10 (Regulation) Under the Long-Term Care Homes Act, 2007 (LTCHA) related to Enhanced Cooling Requirements (came into force on May 15, 2021. The air temperature logs were completed twice daily in two resident rooms and two common areas until June 12, 2021 when air temperature checks were checked three times daily as required. The Environmental Services Manager (ESM) confirmed the home had air conditioning in three designated cooling areas on each unit (lounge, dining room and activity room), confirmed awareness of the new changes to the air temperature monitoring requirements and indicated they had not completed air temperature checks three times daily on each unit and in at least two resident rooms as per the new requirements until July 10, 2021. Failing to monitor air temperatures as required during the period of May 15 to September 15 may lead to uncomfortable or unsafe air temperatures for residents.

Sources: Air Temperature Logs, Amendments to Ontario Regulation 79/10 (Regulation) Under the Long-Term Care Homes Act, 2007 (LTCHA) related to Enhanced Cooling Requirements (came into force on May 15, 2021 and interview with staff. [s. 21. (3)]

3. The licensee has failed to ensure that there was a record of the measurements documented under subsections (2) and (3) for at least one year.

The documented air temperature check logs had no air temperatures recorded from May 15 to 30, 2021 and June 5 to 6, 2021. Environmental Services Manager (ESM) indicated the home had air conditioning in three designated cooling areas on each unit (lounges, dining rooms and activity rooms). The ESM indicated prior to July 10, 2021, the home kept manual air temperature records and then the home switched to a new electronic thermostat sensor system that recorded the air temperatures. The ESM confirmed awareness of the new requirements that were to be implemented for air temperatures

effective May 15, 2021 and could not provide air temperature logs for May 15-30, 2021 and June 5-6, 2021.

Sources: air temperature logs and interview with staff. [s. 21. (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 to ensure the air temperatures in the home are maintained at a minimum of 22 degrees Celsius, that the temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night and that there was a record of the measurements documented under subsections (2) and (3) for at least one year, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #003 and other residents, by identifying and implementing interventions.

Resident #002 was involved in an abuse incident towards resident #003, after resident #003 demonstrated a specified responsive behaviour, and resulted in resident #003 sustaining an injury. A number of weeks later, a second abuse incident occurred involving resident #004 towards resident #003, after resident #003 demonstrated the same responsive behaviour, and resulted in resident #003 sustaining another injury. Resident #003 had a prior history of a number of altercations with resident #002 with no injuries sustained to either resident. All three residents involved were cognitively impaired. Resident #003 had specified triggers that resulted in the specified responsive behaviour and the home had a number of strategies identified. These strategies did not provide specific instructions related to monitoring and assessments. The Behavioural Support Ontario (BSO) lead confirmed that specified assessments and strategies for managing the specified responsive behaviour of resident #002 had not been initiated until after the second resident to resident abuse incident had occurred. One assessment tool had not been updated in over a year and did not include triggers or strategies related to the residents specified responsive behaviour. Staff were also unaware of the frequency of monitoring of resident #003 and there was inconsistency in how frequently resident #003 was monitored. Failure to take steps to minimize altercations and potentially harmful interactions between resident #003 and other residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations led to resident #003 sustaining injuries and can lead to further injuries among residents.

Sources: two CIS, care plan, progress notes, assessments for resident #002, #003 and #004, observations of resident #002, #003 and #004, home's investigations and interview of staff.

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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented and that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

WN #5: 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 :

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On a specified date, the Inspector noted resident #010 was placed on specified isolation precautions. The IPAC lead indicated the resident was on isolation precautions for COVID-19 and should have been placed on additional isolation precautions. On a specified date and time, the Inspector observed a staff member exiting resident #011's room that was on specified isolation precautions for COVID-19. The staff member did not correctly remove their PPE and also did not have appropriate PPE supplies available. Failing to participate in the implementation of infection control for residents on COVID-19 isolation precautions, specifically related to correctly removing PPE and having access to PPE supplies at point of care, places the staff and residents at a high risk for transmission of infections.

Sources: observations and interview with staff.

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 that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent, had an individualized plan of care to promote and manage bowel and bladder continence based on an assessment, and the plan was implemented for resident #007.

On a specified date, a written complaint was submitted to the home from the family of resident #007, alleging staff to resident neglect with continence care. The resident's continence assessment was completed on admission, a number of years earlier and indicating the resident was occasionally incontinent of bladder only and used a specified incontinence product. The resident's care plan indicated the resident was occasionally incontinent of bladder, used a different incontinence product and was on a toileting plan with assistance of one staff. PSW #135 indicated resident #007 was incontinent of both bowel and bladder, was toileted and/or provided continence care and used a different continence product from what was indicated on the assessment and the care plan. The

PSW indicated the level of staff assistance was either one or two staff. PSW #119 confirmed resident #007 was incontinent of bowel and bladder, was not toileted and provided continence care with the same products identified by PSW #135 and always required two staff assistance. Failure to provide the resident with an individualized plan for continence care and based on their assessed needs, may lead to improper continence care being provided.

Sources: observations of resident #007, care plan and continence assessment of resident #007, written complaint and home's investigation, CIS, and interview of staff. [s. 51. (2) (b)]

2. The licensee has failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes for resident #007.

A written complaint was submitted to the home from the family of resident #007, alleging staff to resident neglect with continence care and a lack of continence care supplies. PSW #118 and #119, both confirmed on a specified date, when resident #007 had been incontinent, there was a lack of continence care supplies available. Failure to provide adequate continence care products that are both available and accessible to the residents and staff at all times, and in sufficient quantities, lead to improper continence care for resident #007 and can lead to improper continence care for other residents.

Sources: CIS, observations of resident #007, care plan of resident #007, written complaint and the home's investigation, and interview of staff.[s. 51. (2) (f)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

The licensee has failed to ensure that if unable to provide a report within 10 days to the Director for alleged abuse, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

On a specified date, the home received a written complaint from the family of resident #007, alleging staff to resident neglect. The Administrator confirmed the final report to the Director had not been provided until a number of months later.

Sources: CIS, progress notes and care plan for resident #007, home's investigation and interview of staff.

Issued on this 27th day of September, 2021

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

Original report signed by the inspector.