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: November 9, 2023	
Inspection Number: 2023-1409-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Port Hope, Port Hope	
Lead Inspector Julie Mercer (000737)	**Inspector Digital Signature**
Additional Inspector(s) Catherine Ochnik (704957) Rita Lajoie (741754)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-29, 2023 and October 3-5, 10, 11, 2023.
The inspection occurred offsite on the following date(s): October 6, 10, 2023.

The following intake(s) were inspected:

- An intake related to an allegation of staff to resident neglect.
- An intake related to resident to resident responsive behaviours.
- An intake related to missing or unaccounted for controlled substance.
- An intake related to resident to resident responsive behaviours.
- An intake related to ingestion of foreign substance.
- An intake related to an allegation of staff to resident neglect.
- An intake related to resident to resident responsive behaviours.
- An intake related to resident to resident responsive behaviours.
- An intake related to a fall of a resident resulting in injury.
- An intake related to medication administration.

An additional five intakes were completed in this inspection related to falls.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and 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)

The licensee failed to ensure that the resident was reassessed and their plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, related to an incident that caused an injury to a resident, for which they were taken to hospital and resulted in a significant change to the resident's health status.

Clinical records review of the resident confirmed that they experienced multiple falls, which indicated an increased falls risk level, and the resident was determined to be a high falls risk. The resident's written plan of care was not updated to reflect their high falls risk status.

An interview with the home's former Falls Lead confirmed that the resident was a high falls risk and that the resident's written plan of care should have been updated to reflect their high falls risk status change.

Failure to ensure that the resident's written plan of care was updated to reflect an increased risk for falls placed the resident at risk for subsequent falls and for staff to be uncertain of the resident's falls risk status.

Sources: Fall Prevention and Management Program Policy, a resident's profile, post-falls assessments, progress notes, written plan of care, and interview with former Falls Lead.
[000737]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A CIR was submitted to the Director related to an allegation of staff to resident neglect.

A resident was assisted to the toilet by two Personal Support Workers (PSWs) prior to the end of their shift. The PSWs did not communicate to oncoming staff that the resident remained on the toilet, and both assumed that the other had removed the resident from the toilet.

Review of the home's investigation notes confirmed that the Registered Practical Nurse (RPN) on duty did not check on the resident's status prior to their evening shift ending on date of incident. Investigation notes confirmed that the resident was unable to ring the call bell to indicate to staff that they needed assistance and that oncoming PSWs did not complete rounds to check on the resident until approximately four hours after the resident was initially toileted.

Interview with the Acting Director of Care (ADOC) confirmed that the home's internal investigation confirmed that the incident constituted neglect.

Failing to protect a resident from neglect when they were left unsupervised on the toilet for four hours increased the risk to the resident's safety and may impact the resident's emotional wellbeing.

Sources: Zero Tolerance of Resident Abuse and Neglect Program, home's investigation notes, a resident's progress notes and written plan of care, interviews with staff members.
[741754]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee failed to ensure that ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A CIR was submitted to the Director, for an incident that caused an injury to a resident for which they were taken to hospital and resulted in a significant change to the resident's health status.

Clinical records review of the resident identified that they had experienced frequent falls over several months. During such time, the resident experienced an unwitnessed fall that required clinical monitoring, as indicated in the home's Falls Prevention and Management Programs Policy, and this was not initiated. The resident then experienced an unwitnessed fall that required clinical monitoring, and this was initiated but not complied to. The resident then experienced a subsequent unwitnessed fall and the post-fall assessment was not completed for this fall.

Failure to ensure that the resident was assessed, a post-fall assessment was conducted using a clinically appropriate assessment instrument designed for falls placed the

resident's at risk for undetected injury or change in health status.

Sources: Falls Prevention and Management Program Policy, a resident's written plan of care, post-falls assessments, risk management analysis, clinical monitoring, and progress notes.
[000737]

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a resident's eye drops were administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The Director received a complaint related to medication administration.

Clinical record review of the resident indicated that they were to receive eye drops as prescribed by their physician once daily in the evening to treat a medical condition. The resident did not receive their eye drops as prescribed for three days as the eye drops were not available to be administered.

Interview with the ADOC confirmed that the eye drops had not been given as prescribed for three days as the container was empty and had not been reordered.

Interview with an RPN confirmed that they did not order the resident's eye drops prior to going on vacation and that upon return they were informed by the resident's substitute decision maker that they had not been administered.

Failure to administer a resident's eye drops as prescribed increased the risk to the resident's safety and may impact the resident's visual health.

Sources: The home's MediSystem Policies and Procedures, a resident's progress notes and Medication Administration Record, interviews with staff.

[741754]