Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 18, 2015	2015_195166_0011	O-001967-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North OSHAWA ON L1J 4L1

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

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), KARYN WOOD (601), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 19, 20, 21, 22, 25, 26, 27, 28, 29, 2015.

Critical Incident Logs #O-000328-14,O-000506-14,O-001427-14,O-002035-15,O-002076-15 and Complaint Logs #O-000379-14, O-00491-14 and O-002048-15 were inspected concurrently with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Resident Council President, Family Council Representative, Administrator, Clinical Coordinator/Acting Director of Care, RAI Coordinator, Coding Nurse, Registered Nurses, Registered Practical Nurses, Health Care Aides, Personal Support Workers, Social Worker, Housekeeping, Maintenance staff, Office Administration, Director of Care Clerk, Environmental Services Manager, Physio Therapy Assistant, Occupational Therapy Assistant, Service Provider Technician, Personal Support Worker students and Registered Practical Nursing students.
The Inspectors toured resident home areas, residents' rooms and common areas, observed staff to resident interactions during the provision of care, observed meal services, medication administration and therapy services.
During the inspection, the inspectors reviewed clinical health records, the licensee's investigations documentation, staff education records and the licensee's policies related to abuse, restraints, personal assistive devices(PASD), medication policy related to self administration and complaint procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 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	Legendé 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of verbal abuse of residents is complied with:
The licensee's policy -Resident Abuse-Staff to Resident, reference # OPER-02-02-04 states:
Responding/Reporting -suspected or witnessed abuse
All staff: Immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate(e.g. supervisor, department head)who then must report the incident as required by provincial legislation and jurisdictional requirements.

Log O-0002035-15
A Critical Incident Report(CIR) was received indicating that on an identified date the licensee was made aware of 3 incidents of verbal abuse that had been directed towards Resident #56, 57 and #58, by one staff member, 3 weeks prior to incidents being reported.

Review of the CIR, licensee's investigation, interview with the Administrator and the Clinical Coordinator/Acting Director of Care indicated the incidents of verbal abuse were witnessed by staff
#144, who reported the incidents of abuse to a member of the Registered staff on the day the incidents occurred.
The Registered staff did not report any of the incidents of abuse to the charge nurse, Administrator or Director of Care.

Log O-001427-14

A Critical Incident Report was received indicating that the Director of Care received a letter of concern from staff #127, reporting that the staff had witnessed incidents of verbal and physical abuse directed towards Residents #24, #63 and Resident #65 by staff #125, on 4 separate dates and times.

The allegations of staff to resident verbal and physical abuse were not reported immediately as directed in the licensee's policy Resident Abuse-Staff to Resident, reference # OPER-02-02-04. [s. 20. (1)]

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 by ensuring the licensee's written policy to promote zero tolerance of abuse specifically related to the reporting of all incidents of verbal and/or physical abuse is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Log O-002076-15
The licensee has failed to ensure that the results of the licensee's investigation related to the allegations of staff to resident verbal abuse were reported to the Director.

A Critical Incident Report(CIR) was received reporting an incident of staff to resident verbal abuse.
The CIR indicated that staff#114 was transporting Resident #59 and was overheard using profanity that was directed towards Resident #59.

Review of the CIR, the licensee's investigation and interview with the Clinical Coordinator/Acting Director of Care indicated the results of the licensee's investigation related to this incident of verbal abuse had not been reported to the Director.

Note:Review of the licensee's investigation indicated the PSW #114 is no longer employed in the home. [s. 23. (2)]

2. Log O-000506-14

The licensee has failed to ensure that the results of the licensee's investigation related to the allegation of improper treatment of a resident by a staff was reported to the Director.

A Critical Incident Report was received reporting that staff #115 while pulling Resident #60 backwards in the wheelchair caused the resident's leg to hit the wall(No injuries to Resident #60 occurred).
Staff #115 continued pulling the wheelchair and came across Resident #61 in his/her wheelchair.
Staff #115 physical pushed Resident #61's wheelchair causing the wheelchair to hit a wall. (No injuries to Resident #61 occurred).

Review of the CIR documentation, the licensee's investigation and interview with the Clinical Coordinator/Acting Director of Care indicated the results of the investigation related to improper treatment of Residents #60 and #61 were not reported to the Director.

Note: Review of the licensee's investigation indicated that appropriate actions were taken including education related to zero tolerance of abuse towards residents. [s. 23. (2)]

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 results of every investigation undertaken by the licensee specifically related to abuse and or improper treatment is reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a physical restraining device was included in the plan of care for Resident #4, #5, #11 and Resident #31.

The plan of care indicates that Resident #4 self propels in the wheelchair and is at risk for falls related to self transferring and not understanding the resident's physical limitations.

The plan of care for Resident #4 does not identify the use of the alarmed velcro belt as a restraint.
Resident #4 was asked several times by staff to undo the seat belt on the wheelchair.
Resident #4 was not able to undo the alarmed velcro seat belt when asked.

The plan of care identifies that Resident #5 is at risk for falls related to sliding out of the wheelchair. The plan of care for Resident #5 does not identify the use of a front facing seat belt as a restraint.

Resident #5 was observed sitting in a wheelchair with a front facing seat belt fastened. The resident was asked by staff to open the lap belt but the resident was unable to unlock the lap belt.

During an interview with Acting Director of Care(DOC) and RAI Coordinator, both explained that Resident#5 was not supposed to have a lap belt in place and was also sitting in the wrong wheelchair,
and that Resident #5's wheelchair had been taken home by family. Resident #5 was given the use of another wheelchair that had a seat belt attached to the chair which staff applied.

The plan of care identifies Resident #11 is at risk for falls related to self transferring.
Resident #11 was observed sitting in the wheelchair with an alarmed velco seat belt in place.
Interview with RPN 101 indicated that the resident was able to undo the belt. When the RPN asked the resident to undo the velcro belt, the resident appeared not to understand the question and could not undo the belt.

Resident #31 was observed sitting in his wheelchair with an alarmed velcro seat belt in place.

During the observation of Resident #31 ,PSW #100 indicated that Resident #31 was unable to unfasten the velcro seat belt, and that it was in place to prevent the resident from standing. PSW #100 indicated that the alarmed velcro seat belt was not considered a restraint.
Resident #31 was unable to undo the velcro seat belt when asked.

During an interview with the DOC and RAI Coordinator indicated that the home did not

recognize the alarmed velcro seat belt in the home as restraints. [s. 31. (1)]

2. The licensee has failed to ensure that a physician or the registered nurse in the extended class has ordered or approved the use of a restraining device for Residents #4, #5, #11, #31.

Review of the physician's orders and plans of care for Residents #4, #11 and #31 did not identify the use of the alarmed velcro seat belt or for Resident #5, the use of a front closing seat belt as a restraining device.

Resident #4, #5, #11 and #31 were not able to undo the seat belts when asked to do so by staff. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the plan of care include the consent by the resident or if the resident is incapable, by the SDM.

Review of the clinical documentation, including consent forms, plan of care and care conferences for Residents #4, #11 and #31 did not provide evidence of consent by the residents' SDMs for the use of the alarmed velcro seat belt as a physical restraint and for Resident #5, the use of a front closing seat beat.

Note: During this inspection, in the clinical records, a physician's order, consent from the Residents' SDMs and monitoring tools had been initiated for the use of a restraining device for Residents #4,#11 #31 and the seat belt was removed for Resident #5. [s. 31. (2) 5.]

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 all residents who require restraining by a physical device has been ordered by the physician, registered nurse in the extended class, included in the residents' plan of care and that the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents #7, #14, #29, #30, #50, #66, #67, #69, #71 and #72 were bathed, at a minimum twice a week by the method of his/her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The existing practice in the home is to complete a "Bath shift Report" for any missed baths on the units. The Bath shift report" is then signed off by the Registered staff on the unit and provided to the DOC clerk.

Review of the "Bath shift report" and the POC documentation for May 23, May 24 and May 25, 2015 identified that Residents #7, #14, #29, #30, #50, #66, #67, #69 ,#71 and #72 did not receive a bath.

During an interview staff #112 indicated that if a bath had been provided to make up for the missed baths it would be documented on the POC by the PSWs.

Residents #7, #14, #29, #30, #50, #66, #67, #69, #71 and #72, were not able to be interviewed related to bathing due to their present cognitive status.

During an interview, staff #141 indicated that no extra baths had been completed in order to make up for the baths that the above mentioned residents did not receive. [s. 33. (1)]

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 to ensure that residents are bathed, at a minimum twice a week by the method of his/her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

Review of the RN staffing schedule and interview with the DOC clerk indicated there was not a registered nurse in the building during the night shift on the following dates:
May 1, 11, 13, 14, 15, 19, 20, 21, 23, 24,and 25, 2014. A total of 11 shifts were not filled by an RN in the month of May 2014. [s. 8. (3)]

WN #6: 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 :

1. The licensee has failed to comply with O.Reg 79/10, s.8.(1)b with regards to the medication management system policies and procedures as required under O.Reg.79/10,s.114(1).

Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The home's policy on Self Administration, id # 11-23 states " Residents are permitted to self-administer medications only when a Physician or Nurse Practitioner's written order is present in the resident's health record. This order must be re-ordered with the Three Month Medication Review".

The policy also indicates that the MAR/TAR/eMAR sheet should clearly indicate that the resident is self- administering their own medications and contain the appropriate code for all medications self -administered.

During an interview with Resident #32, Inspector #194 observed a decongestant on the bed side table in the resident's room. The resident, who is cognitively intact, explained that he/she self- administers daily.

Interview with staff #112, indicated that Resident #32 does self administer the decongestant daily.
Interview with Staff #139 confirmed the resident is self-administering the decongestant.

Review of the physician's order indicate the resident was prescribed the decongestant.

There is no evidence that the self- administration of this medication has been approved by the physician. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair

On May 20, 2015, during stage one of the RQI, inspector #601 observed a large area of damage to the dry wall with insulation material exposed behind bed in room #216-2.

Review of Maintenance Request Log indicated an entry on May 8, 2015 that the dry wall behind Resident #25's bed has a huge hole with falling dry wall and insulation.

On May 26, 2015 during interviews, the Support Services Manager in charge of Environmental Services and maintenance person Staff #128 indicated that they were not aware of the damage to the dry wall in room #216-2. The damage to the dry wall was causing two holes behind resident's bed measuring 24 x 12 inches and 6x6 inches as measured by Staff #128.

During the interviews, the Support Services Manager and Staff #128 indicated that the damage to dry wall should have been repaired once noticed.

On May 27, 2015 it was noted that the dry wall damage was repaired in room #216-2.

Furnishings, equipment and building surfaces that are not maintained in a safe condition and a good state of repair are a potential risk to the health, comfort, safety and well being of residents. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Log O-002035-15
The licensee has failed to ensure that Resident #56, 57 and Resident #58's SDMs were notified within 12 hours upon becoming aware of any alleged verbally abuse that had been directed towards Residents #56, #57 and #58.

A Critical Incident Report was received reporting that on specified date, the licensee had been made aware of allegations that one staff had been involved in 3 separate incidents of staff to resident verbal abuse which had occurred approximately 3 weeks prior to incidents being reported.

Review of the critical incident documentation, the licensee's investigation and interview with the Administrator and the Clinical Coordinator/Acting Director of Care indicated Resident #56, 57 and #58 SDMs were not notified at any time of the allegations of verbal abuse directed towards the above mentioned residents. [s. 97. (1) (a)]

2. Log O-002035-15
The licensee has failed to ensure that Residents #56, #57 and #58's SDMs were notified of the results of the alleged verbal abuse that had been directed towards Residents #56, 57 and #58.

A Critical Incident Report was received reporting that on specified date, the licensee had been made aware of allegations that one staff had been involved in 3 separate incidents of staff to resident verbal abuse which had occurred approximately 3 weeks prior to incidents being reported.
The licensee initiated an internal investigation upon becoming aware of the allegations.

Review of the critical incident documentation, the licensee's investigation and interview with the Administrator and the Clinical Coordinator/Acting Director of Care indicated Resident #56, 57 and Resident #58 SDMs were not notified of the results of the investigation into the allegations of verbal abuse directed towards the above mentioned residents.

Log O-000506-14
The licensee has failed to ensure that Resident #60 and 61 and the residents' SDMs were notified of the results of the allegations of abuse related to improper care investigation immediately upon the completion.

Review of the critical incident documentation, the licensee's investigation and interview with the Clinical Coordinator/Acting Director of Care concerning the allegations of abuse related improper care did not provide evidence that Resident #60 and 61 and the residents' SDMs had been notified of the results the investigation.

Log O-001427-14
The licensee failed ensured that Resident # 24, #63 and #64 and the residents SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Review of the licensee's investigation ,the critical incident documentation and interview with the Clinical Coordinator/Acting Director of Care indicated the residents and the residents SDMs were not notified of the results of the investigation. [s. 97. (2)]

WN #9: 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. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Log O-000506-14

The licensee has failed to ensure that the report to the Director included the analysis and follow-up actions:

Review of a Critical Incident Report, which reported the incidents of improper treatment of Residents #60 and #61 by staff #115, the licensee's investigation and interview with the Clinical Coordinator/Acting Director of Care, indicated that the long-term actions planned to correct the situation and prevent recurrence, were not reported to the Director.

Log O-0002076-15

Review of a Critical Incident Report, reporting an incident of staff to resident verbal abuse directed towards Resident #59 by staff #114, the licensee's investigation and interview the Clinical Coordinator/Acting Director of Care indicated that the long-term actions planned to correct the situation and prevent recurrence, were not reported to the Director. [s. 104. (1) 4.]

Issued on this 18th day of June, 2015

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

Original report signed by the inspector.