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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2018	2017_673554_0025	016669-17, 022824-17	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 10, 15, 16, and November 17, 2017

Intakes #016669-17, and #022824-17.

Summary of Intakes:
1) #016669-17 - Complaint - alleged care related issues;
2) #022824-17 - Complaint - alleged care related issues, management of responsive behaviours, and short staffing.

A non-compliance under O. Reg. 79/10, s. 141 (1), specific to Intake #022824-17, will be identified in Inspection Report #2017_673554_0026, which was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Clinical Coordinator, RAI-Coordinator, Social Worker, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Behaviour Supports Team members, Family and residents.

During the course of this inspection, the inspector toured the home, observed staff to resident and resident to resident interactions; reviewed clinical health records, written complaints related to resident #001, licensee's Staffing Plan, and the Staffing Contingency Plan, and reviewed licensee specific policies, relating to SBAR (Situation, Background, Appearance, Recommendation), Continence Management Program, Skin and Wound Program, and Complaints.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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 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. 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that 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.

Related to Intake #016669-17:

Resident #001 has history of physical impairment. Resident #001 has a Substitute Decision Maker for care decisions. Resident #001 is identified as being at risk for altered skin integrity.

The Substitute Decision Maker (SDM) for resident #001 indicated, to Inspector, that resident #001's condition changed on an identified date. SDM indicated voicing concerns to Registered Nurse #100, on an identified date as to the identified condition, and requested that RN #100 contact the physician about his/her concerns that same day. SDM indicated that as of today, approximately seventeen days later, the physician has not been contacted regarding the identified concerns.

The clinical health record, for resident #001, was reviewed for the period of approximately one and half months.

The is no documentation to support that Registered Nurse #100 or any other registered nursing staff followed up with an initial fax sent, by RN #100, on an identified date. Nor is there documentation to support that a second fax, sent sixteen days later, was followed up by registered nursing staff, when there had been no response by the Physician for resident #001.

The Physician, for resident #001, indicated in his/her progress notes 'that staff have asked that resident #001 be assessed'. Physician indicated his/her documentation, that nursing staff have been attending to an identified concern specific to resident #001 since an identified date. Physician indicated that 'SDM for resident #001 was concerned and asked that resident #001's physician assess the area'. Physician indicated being unavailable during an identified week, and indicated that no fax was received at the office during this same time period. Physician further indicated there had been no notes requesting an assessment (of resident #001) on the doctor's clipboard.

Registered Nurse #100, as well as the Director of Care (DOC) indicated that registered nursing staff should have contacted resident #001's physician, and or an On Call Physician when no response had been received to faxes sent, especially noting SDM's concern. Registered Nurse #100, and the DOC indicated there is no current process in place for registered nursing staff to follow up with faxes sent to physician's ensuring concerns are addressed.

The licensee failed to ensure that 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, specifically as such related to resident #001's identified condition.

2. The licensee failed to ensure that the resident was reassessed, and the plan of care revised when the care set out in the plan had not been effective, and or different approaches considered in the revision of the plan of care.

Related to Intake #016669-17:

Resident #001 has a history which includes physical impairment. Resident #001 has a

Substitute Decision Maker for care decisions. Resident is dependent on staff, for most, activities of daily living, including toileting.

The Substitute Decision Maker (SDM) for resident #001 indicated, to Inspector, that resident is not being toileted by staff. SDM indicated being told by nursing staff that there was a plan in place for resident #001.

Resident #001 indicated, to the Inspector, resident #001 indicated that staff take too long to toilet him/her, and as a result he/she becomes involuntary. Resident #001 indicated that staff only toilet him/her for a specific reason. Resident #001 denies refusing toileting by staff. Resident #001 indicated that his/her preference to sleep in till a specific hour.

The clinical health record, for resident #001, was reviewed for the period of approximately five months, with the following documented:

Written Care Plan: (identified dates):
- Toilet use – interventions include, extensive assistance of two staff using an identified transfer device; identified plan, starting at an identified hour.

Resident #001 was observed, by the Inspector, to be in bed until an identified hour during a three day observation period during this inspection.

Personal Support Workers (PSW) #108 and #109 indicated, to the Inspector, that resident #001 is toileted when resident requests. Both PSW's indicated that they normally toilet resident #001 following an identified meal, and this is normally the first time resident #001 is toileted during the identified shift. Both indicated that resident #001 will refuse toileting.

Registered Practical Nurse (RPN) #110 indicated, to the Inspector, that resident is toileted as resident asks. RPN #110 indicated having no awareness of an identified plan for resident #001. RPN indicated being unaware that resident #001 refuses toileting.

Personal Support Worker # 103, and Registered Practical Nurse #104, both indicated to the Inspector, that resident will refuse to get up for an identified meal, and will refuse toileting throughout the shift. Registered Nurse #100, and RPN #104 indicated that the identified plan, which is to begin at an identified hour daily, would not be practical as resident often sleeps till a specific hour.

The RAI-Coordinator provided, the Inspector with, a document entitled 'Point of Care, Resident Response Rate Report'. The document provides details that resident #001 refused toileting an identified number of times during a five month period.

Registered Nurse #100, RAI-Coordinator, and the Director of Care all indicated that the plan of care, specifically toileting, and continence care/management should have been revised noting resident's preferences (sleep-wake), and noting that staff were aware that resident #001 will refuse toileting.

The licensee failed to ensure that the resident was reassessed, and the plan of care had been revised when the care set out in the plan had not been effective, specific to toileting and continence care/management, for resident #001.

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 there is a process in place, and monitored, ensuring that 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; and ensuring that residents are reassessed, and the plan of care is revised when the care set out in the plan had not been effective, and or that different approaches considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward a written complaint to the Director that had been received concerning the care of a resident or the operations of the home.

Related to Intake #016669-17:

The Substitute Decision Maker (SDM), for resident #001, submitted a written complaint, to the licensee or designate on an identified date. The written complaint indicates that resident #001's condition, changed approximately fifteen days earlier. SDM indicated in the written complaint that a request was made by him/herself (SDM), to an identified Registered Nurse an identified date, for the physician be contacted. SDM indicated in the written complaint that resident #001's identified condition has since worsened, and that resident has not been assessed by a physician, nor has there been any follow-up by registered nursing staff to a physician regarding the identified condition, or as to a fax communication, allegedly forwarded to resident's physician on an identified date.

The Director of Care (DOC) indicated receipt of the written complaint, and indicated, to the Inspector, that the written correspondence (complaint) was dated as identified by the SDM, and indicated that he/she (the DOC) would have received it the next day.

The Director of Care indicated, to the Inspector, that the written complaint had not immediately been forwarded to the Director. The Director of Care indicated that the first attempt to forward the written complaint to the Director was on an identified date, which was approximately six days after receipt of the written complaint The Director of Care indicated being aware that written complaints regarding a resident or the operations of the home are to be forwarded immediately to the Director.

The licensee failed to ensure that a written complaint received concerning the care of resident #001, and the operations of the home was immediately forwarded to the Director. [s. 22. (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 there is a process in place, ensuring that written complaints received regarding care of a resident or the operations of the home, are immediately forwarded to the Director, to be implemented voluntarily.

Issued on this 8th day of January, 2018

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

Original report signed by the inspector.