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
Dec 30, 2020	2020_643111_0026	004199-20, 014785-20	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 Peterborough
860 Alexander Court Peterborough ON K9J 6B4

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): December 14 to 17, 2020

Two critical incidents were inspected concurrently during this inspection:
- Two CIR's related to falls with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping (HSK), Janitor, residents and resident assistants (RA).

During the course of the inspection, the inspector toured the home, observed a resident room, reviewed resident health records, falls statistics meeting minutes and falls prevention policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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 :

The licensee had failed to ensure that staff and others involved in the different aspects of care collaborate with each other, in the assessment of a resident, so that their assessments were integrated, consistent with and complemented each other related to falls prevention.

A resident with specified diagnoses, pain and unsteady gait had sustained a number of falls over a period of time, all occurring in a specified area. After the first fall, the resident’s condition continued to deteriorate and recommended monitoring, with no indication when that was to occur. One fall prevention intervention was contraindicated. One fall resulted in an injury for which the resident was transferred to hospital, had a significant change in condition resulting in including use of a different mobility aid, additional analgesic and an ongoing treatment. The last fall resulted in a serious injury and subsequent death. The resident's care plan identified a different level of risk, a different mobility aid in use and no indication of falls prevention interventions being used or contraindicated. There was no collaboration between staff in the assessment of the resident to indicate they were integrated, consistent or complimented each other, as the resident no longer used the initial mobility aid, there was no direction related to the pain or other interventions to be used related to other medical conditions, that contributed to falls risk. The care plan had not been updated with interventions indicated by some of the staff. Findings were reviewed with the DOC and confirmed that there was a lack of collaboration among the nursing staff related to the assessment of the resident. Staff at different levels assessed the residents needs differently and inconsistently with one another. The risk to the resident was apparent as the resident suffered a serious fall leading to their death.

Sources: CIR, Progress notes, post-fall assessments, Morse fall risk, risk management reports and care plan for a resident, weekly falls statistics and staff interviews.

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 and others involved in the different aspects of care collaborate with each other, in the assessment of residents, so that their assessments are integrated, consistent with and complemented each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, regarding the proper use of the surgical procedure mask and maintaining two meters distance from others, while not a wearing a mask in order to protect residents from COVID-19.

During the course of the inspection, on a number of occasions, staff were observed with their mask sitting under their nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 dated October 16, 2020, all staff of long-term care homes must always wear a surgical procedure mask for the duration of their shift. When staff are not in contact with residents, staff may remove their surgical procedure mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19. The lack of adherence to Directive #3 related to the use of surgical/procedure mask and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective date October 16, 2020), observations throughout the home and staff interviews.

Issued on this 31st day of December, 2020

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

Original report signed by the inspector.