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
Apr 28, 2021	2021_640601_0007	024687-20, 002256-21, 002615-21, 003267-21, 004932-21, 004949-21	Complaint

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

KARYN WOOD (601)

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): On-site March 12, 16, 17, 18, 19, 23, 2021 and Off-site on March 22, 26, and 29, 2021.

The following intakes were completed in this Critical Incident System (CIS) Inspection Report:

Six logs related to allegations of staff to resident neglect related to multiple care concerns and the Substitute Decision Makers (SDMs) request to be an essential caregiver being denied.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Care Quality (DOCQ), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Clinical Care Coordinator (CCC), Housekeeper (HSK), Public Health Inspector (PHI) , residents and their family members.

The inspector also reviewed resident health care records, policies, observed the delivery of resident care and services, including staff to resident interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

4 WN(s)
3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents received visitors of their choice without interference when their Substitute Decision Makers (SDMs) request to be an essential caregiver was denied.

The Ministry of Long-Term Care (MLTC) received four complaints that the residents' SDMs request to be an essential caregiver was denied by the home, and they were not able to assist with the residents care needs. The residents' SDMs indicated they were concerned the residents care needs were not being met and prior to the COVID-19 pandemic the resident's family had visited the residents to provide cognitive stimulation and meaningful connection.

A resident's SDM sent the Administrator and Director of Care (DOC) an email requesting to be an essential caregiver based on their ability to provide resident care and services to maintain the resident's good health. The Administrator's email response to the resident's SDM indicated the resident's SDM was not an essential service. The Administrators email response further indicated that resident's who were actively dying were the only resident's that could have visitors enter the building. According to the Administrator's email response, the home had been restricting visitors since the pandemic began in March 2020.

Directive #3, effective May 21, 2020, directed that Long-Term Care Homes (LTCHs) must be closed to visitors, except for essential visitors. Essential visitors include a person performing essential support services (e.g. food delivery, phlebotomy, maintenance, family or volunteers providing care services and other health care services required to maintain good health) or a person visiting a very ill or palliative resident.

Directive #3, effective June 10, 2020, directed that the aim of managing visitors was to balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life.

The DOC confirmed that both residents' SDMs had requested to be an essential caregiver and this request had been denied. The DOC acknowledged the home’s visitor policy during COVID-19 included to allow essential caregivers. The DOC indicated the decision to not allow essential caregivers was based on the safety for residents and staff working in the home.

According to the Peterborough Public Health Inspector (PHI), the homes refusal to permit essential care givers to enter the LTCH from a public health perspective was not justified when the Medical Officer of Health, Directive #3 provided the homes with direction on how this could be done safely.

Directive #3, effective December 7, 2020 that was in effect at the time of the inspection specified that essential caregivers are the only type of visitors allowed when a resident is self-isolating or symptomatic, or a LTCH is in an outbreak, or the LTCH is located in a public health unit region where there is evidence of increasing/significant community transmission i.e., Orange (Restrict), Red (Control) or Grey (Lockdown) levels in the provincial COVID-19 Response Framework: Keeping Ontario Safe and Open.

LTCHs are responsible for supporting residents in receiving visitors while mitigating the risk of exposure to COVID-19. Further, homes are responsible for establishing and implementing visiting practices that comply with Directive #3 and the Minister's Directive. The residents' emotional well-being was at risk when the resident’s SDMs request to be an essential caregiver was denied by the home.

Sources: COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, with revision date of May 21, 2020, June 10, 2020, and December 7, 2020, interviews with the Peterborough PHI, DOC, Administrator, and residents SDMs. [s. 3. (1) 14.]

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 following rights of residents are fully respected and promoted:14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, 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 :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding maintaining two metres distance from others while not wearing a mask.

Inspector #601 observed residents sitting in chairs next to each other in common areas and there were residents in wheelchairs placed side by side in the common areas, the dining room tables had two, three or four residents seated together, with no physical barrier separating the residents. The residents seated side by side in these common areas were not two meters distanced from each other, and they were not wearing a surgical mask.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to Long-Term Care Homes (LTCH) 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 LTCHs. As per Directive #3 effective on December 9, 2020, LTCHs must have a plan for and use related to staff and resident cohorting, to the extent possible, staff and resident cohorting as part of their approach to preparedness, as well as to prevent the spread of COVID-19 once identified in the LTCH.

The Director of Care (DOC) indicated that it was not possible for the residents to maintain physical distancing in the dining room and common areas due to the design of the building. They further indicated there were no further plans in place for residents to maintain a physical distancing of two meters during meal service or within the common areas.

The lack of adherence to Directive #3 related to physical distancing of residents presented an actual risk of exposing the residents to COVID-19, if the home were to experience an outbreak.

Sources: Directive #3 dated December 7, 2020 (version effective date December 9, 2020), observations throughout the home, and interview with the DOC. [s. 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 ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee has failed to ensure that a resident's plan of care included clear direction to staff related to when the resident could be transferred without the use of the transfer device.

The Ministry of Long-Term Care (MLTC) received a complaint that a resident had an unexplained injury and was supposed to be transferred using a specified transfer device, with the assistance of two staff.

The physiotherapist assessment determined the resident required a specified transfer device, with two staff assistance. The plan of care for the resident directed to use a specified transfer device, with the assistance of two staff for all transfers, and the plan of care also said that staff would provide two staff extensive assistance, as needed for transfers. The plan of care reviewed did not include directions to staff to determine when it would be appropriate to use two staff extensive assistance, when transferring the resident.

The internal investigation determined the cause of the unexplained injury could have been caused while transferring the resident based on the location of the injury. The DOC indicated they had spoken with staff who had been working and they were not able to confirm the cause of the injury based on staff interviews. The DOC further indicated that staff education had been provided to all staff providing the resident's care to ensure the specified transfer device, with two staff assistance was always used, when transferring the resident.

The resident was at risk for injury due to the lack of clear direction for staff providing care to the resident related to when the resident required the specified transfer device, or two staff extensive assistance without the use of the specified transfer device.

Sources: A resident's care plan, progress notes, and physiotherapy assessment's, interviews with staff and the DOC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff involved in the resident's care collaborated with each other so that their assessments were integrated, consistent and complemented each other for a specified month, when the resident had a change in condition.

The Ministry of Long-Term Care (MLTC) received a complaint with allegations of staff to resident neglect related to the management of a resident's health condition.

The physician documented the resident was experiencing a change in condition and prescribed a medication. The resident refused some of the medication prescribed to treat the resident's medical condition. Approximately a week later, the Registered Dietitian (RD) documented the resident had a specified change in weight. Later in the month, the resident was experiencing a different medical condition that required a medical test. The resident's progress notes indicated the resident was experiencing a decline in condition and was experiencing an elimination problem for several days, during the specified month.

There was no evidence that the resident's prescribed specified protocol medication was administered, as required when the resident was experiencing an elimination problem.

The Director of Care (DOC) and RN reported they did not recall the resident experiencing an elimination problem nor did they recall collaborating with each other, the physician or the RD regarding the resident's elimination problem. There was no documentation indicating that staff collaborated with the resident’s physician or the RD as directed in the resident's prescribed specified protocol. The resident was at risk for health complications when staff did not collaborate with each other, the RD, and the physician when the medication was not utilized, as prescribed by the physician.

Sources: A resident progress notes, plan of care, POC flow sheet documentation, Medication Administration Record (MAR), Medical Directives for Extendicare Peterborough related to Specified Routine, interviews with PSW, RN, and the DOC. [s. 6. (4) (a)]

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 ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident and 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a medication incident involving a resident was reviewed and analyzed, and that corrective action was taken when the resident potentially missed three doses of a medication.

A resident's medication was increased from twice a day to three times a day and the pharmacy dispensed the medication in a medication vial. On a specified date, RPN #111 initiated a medication incident report alleging that the resident had missed three doses of their medication, at a specified time. RPN #112 had documented on the resident's medication administration record that they had administered the resident's medication, at the specified time. The Director of Care (DOC) indicated they had reviewed the medication incident report completed by RPN #111. They further indicated there was no further written record of the medication incident, RPN #112 was not interviewed, the medication incident was not analyzed, and no corrective action was taken. There was no documentation to indicate that the pharmacy had reviewed the medication incident. The resident was at risk when there was no analysis to determine if they had received their medication, as prescribed by the physician.

Sources: A resident's progress notes, Medication Administration record (MAR), Medical Pharmacies Medication Incident, Original medication report, interview with the DOC. [s. 135. (2)]

Issued on this 19th day of May, 2021

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

Original report signed by the inspector.