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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2021	2021_861194_0012	010647-21, 011090-21, 011100-21, 011516-21	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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): September 23, 24, 27, 28, 29, October 5, 2021

**Inspected, Log #011516-21 and Log #010647-21, related to bed refusal
Inspected Log #011090-21 related to discharge of a resident and Log #011100-21, related to resident to resident abuse**

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), COVID-19 screeners, Best Practice Co ordinator, Clinical Co ordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Peterborough Regional Health Care Manager, Local Health Integration Networks (LHIN) Placement Co ordinator and Senior Manager.

During the course of the inspection, the Inspector reviewed, clinical health information of identified resident related to Internal abuse investigation, admission packages, IPAC documentation related to Continuous Positive Airway Pressure (CPAP) . The inspector, observed IPAC practices at the home.

**The following Inspection Protocols were used during this inspection:
Admission and Discharge
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect the resident #010 from abuse by resident #001 on an

identified date.

Definition of Physical abuse: The use of physical force by a resident that causes physical injury to another resident.

Critical Incident Report (CIR) reported that resident #001 abused resident #010. Both residents were walking in the hallway with their mobility aides. The residents met, words were exchanged and resident #001 abused resident #010. Resident #010 abused resident #001.

The plan of care for resident #001 identified triggers and provided interventions for the responsive behaviour. The resident exhibited a number or responsive behaviours over a defined period of time.

PSW #124 stated they were not surprised that there was an altercation, both residents were similar and had unpredictable responsive behaviours. PSW confirmed that resident #001, "did not like it here at all". The PSW stated that the residents behaviours were building and it was going to erupt.

RPN #121 confirmed that resident #001 and #010 shared a bathroom resulting in responsive behaviours. Staff would interfere and tell them to stop. The RPN confirmed that this was effective. Resident #001 would exhibit a particular responsive behaviour and staff knew to keep other co-residents out of resident #001’s way.

PSW #108 confirmed that resident #001 had responsive behaviours which were unpredictable and would be triggered without being provoked.

RN #119 confirmed that the resident #001's responsive behaviours were unpredictable.

During telephone interview with Inspector # 694426, DOC confirmed that resident #001 had not been identified on their admission package with any responsive behaviours. There was no behavioural assessment completed and no psychiatric medications. The home received a report from the hospital that the resident had exhibited responsive behaviours. The resident for the most part, was non-verbal, unless there was something that they did not like. Failing to protect residents from abuse by anyone, increases the risk of potential injury to co-residents.

Sources: Clinical health record for resident #001, internal abuse investigation and staff

interviews. [s. 19. (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 that the residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to approve application for admission to the home, for resident #002, #003 and #014.

A Care Coordinator with Local Health Integration Network (LHIN) #123 confirmed that the home had provided a verbal bed refusal for resident #003 and #002, for lack of physical facilities necessary for care. .

The communication log between LHIN and the home confirmed that Resident #014's referral was received and was refused by the home for lack of physical facilities necessary for care.

Manager #128 at Peterborough Regional Health Care (PRHC) confirmed that they had provided IPAC information to local LTC homes that identified treatments could be managed in semi-private accommodations when the preferred private accommodation were not available.

The DOC has confirmed that resident #002 , #003 and #014 were refused admission. Failure to properly assess the resident applications prevents residents who can be cared for at the home, the opportunity to be placed in the home of their choice.

Sources: Concerns received from SDM's and interviews [s. 44. (7) (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 by ensuring to review the assessment and information and approve the applicants admission to the home unless grounds identified in the legislation are met, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the Infection Prevention and Control Program.

On two separate occasions, the Inspector was met at the front door of the home by different screeners, who were not wearing eye protection when stepping past the Plexi glass partition. Both screeners confirmed that they were aware that eye protection was required.

PSW #113 assisted resident #004 and #005 from the dining room, with no hand hygiene (HH) offered or provided post meal. PSW #113 stated that the unit was very busy, and they were not fully staffed. PSW #103 left a resident's room after providing nourishment and no HH was completed. PSW #116 assisted resident #008 out of the dining room with no HH offered or provided post meal. PSW #116 confirmed that HH should have been completed.

PSW #108 entered resident #007's room under contact precautions, wearing gloves but no other PPE. When leaving the room, PSW #108 removed their gloves but no HH was completed, confirming that the resident was assisted back to bed and their brief had been checked but did not require changing. PSW #108 stated that PPE were not required as the resident's brief had not been changed. PSW #117 entered resident #009's room under contact precautions to answer a call bell. PSW #117 reopened the resident's door to apply gloves. When leaving the room, PSW # 117 confirmed that the resident had been assisted to the toilet and peri care had been provided. PSW #117 confirmed that they should have been wearing PPE as indicated in the signage.

Resident #012 and #013 were identified by RN #118 as requiring contact precaution. It was observed by Inspector #194 that there was no contact precaution signage outside the resident's rooms. Failing to ensure that staff participate in the implementation of the IPAC program, increases the risk for the spread of infections at the home.

Sources: Observation of the IPAC practices at the home and interviews. [s. 229. (4)]

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 that all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to provide a written notice to the resident and the SDM, setting out a detailed explanation of the supporting facts, as the relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Resident #001 abused a co-resident at the home resulting in injury. The resident was transferred to the hospital and subsequently discharged from the home.

The DOC has confirmed that the SDM of resident #001 was not provided a written notice of the resident's discharge with a detailed explanation of the supporting fact related to the home and the resident's condition and requirements for care. Failure to provided a written detailed explanation of the supporting facts related to the situation, limits the opportunity for a response or reply when not in agreement.

Sources: resident #001's clinical health records and interview. [s. 148. (2)]

Issued on this 22nd day of October, 2021

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

Original report signed by the inspector.