Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 08, 2023

Inspection Number: 2023-1088-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Peterborough, Peterborough

Lead Inspector	**Inspector Digital Signature**
Chantal Lafreniere (194)	Chantal Lafreniere Digitally signed by Chantal Lafreniere Date: 2023.12.12 11:41:09 -05'00'

Additional Inspector(s)
Patricia Mata (571)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15 - 17, 20 - 22, 2023
The inspection occurred offsite on the following date(s): November 23, 2023

The following intake(s) were inspected:

- Intake: #00092843 -related to fall with injury.
- Intake: #00093378 - Complaint related to care of a resident.

The following intakes were completed in this inspection:

NOTE: A Written Notification (WN) related to FLTCA, 2021, s. 28 (1) 1, O. Reg 246/22, s. 57 (1) 4 and O. Reg 246/22 s. 108 was identified in a concurrent inspection #2023_1088_0002 (Intake # #00088886) and issued in this report.

Intake #00093017 was related to falls.

Intakes: #00004843, Intake #00006410, Intake #00090012, intake #00099545, related to fall, resulting in injury with a significant change in condition.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

1. The licensee failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm is immediately reported.

Rationale and Summary:

Complaints were received by the Director related to provision of care of the resident.

A resident was injured related to how they were positioned in bed. The family verbalized to an RPN and RN that they were not happy about the care provided to the resident.

When the licensee received a verbal complaint from a family, related to the residents care, it was not immediately reported. As well, the DOC failed to ensure that two weeks later when speaking to the family about their concerns related to care of the resident, it was immediately reported.

The resident was at risk for potential improper care when the allegations related to care were not immediately reported.

Sources: Family complaint received by the Director, resident clinical health records and interview with staff. (RPN #120, RN #121 and DOC). [194]

2.The licensee failed to report an allegation of improper care of a resident that resulted in harm or risk of harm to the resident, immediately to the Director.

Rationale and Summary:

The family members of a resident met with the Clinical Coordinator (CC) #136 and the Director of Care-Quality (DOCQ) #139 to discuss concerns the family had with improper care being provided to the resident.

CC #136 indicated that they could not find their notes related to the meeting or recall the details of the complaint and were unable to recall if an investigation was conducted.

The complaint and allegation of improper care by PSW #102 was not reported to the Director.

When the complaint allegation for improper care was not immediately reported to the Director, the resident was at risk for further incidents.

Sources: resident clinical health records, interview with CC #136, review of complaint log. [571]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

1. The licensee failed to ensure that the monitoring of a residents response to, and the effectiveness of, the pain management strategies were completed.

Specifically, the registered staff did not assess for post analgesic score in their pain assessments.

Rationale and Summary:

A complaint was received by the Director, from a resident's family member expressing concerns related to the care of the resident.

Resident #013 was administered analgesic for a complaint of pain of 10/10 on the severity pain scale.

There was no evidence to support that a clinically appropriate assessment instrument specifically designed for pain was used when the resident continued to express pain. RPN #120 confirmed that no pain assessment was completed for resident #013.

Director of Care Quality (DOCQ) indicated that the expectation of the home is that the staff follow the pain policy related to the pre and post pain scores. The DOCQ indicated that when a pain score is greater than or equal to 4 the registered staff would be expected to complete the full pain assessment. The DOCQ also indicated that post pain score should be completed within an hour of the pain medication administration.

Failing to ensure that responses to, and the effectiveness of the pain management strategies for the resident increased the risk of prolonged pain for the resident.

Sources: Review of complaint from family of a resident, resident's progress notes, Medication administration records and interview with staff (DOCQ, RPN #120). [194]

2. The licensee failed to ensure the resident's responses to, and the effectiveness of analgesic were monitored.

Rationale and Summary:

A complaint was received by the Director from the family of resident #021 regarding ineffective pain control.

RPN #139 administered analgesic for breakthrough pain to a resident. RPN #139 did not use a clinically appropriate assessment instrument specifically designed for pain which is used to monitor the resident's response to and effectiveness before administering analgesic to the resident.

The licensee's pain management program directs staff to complete and document pain assessments using their electronic clinically appropriate assessment tool when a resident reports pain and after an intervention. This tool allows for an in-depth pain assessment so that a resident's response to and the effectiveness of pain management strategies can be monitored.

The DOC indicated staff should use the electronic pain assessment tool when a resident reports pain.

Failure to complete the licensee's pain assessment tool restricted staffs' ability to fully assess the resident's response to and effectiveness of the analgesic which put the resident at risk for ineffective pain management.

Sources: resident's clinical health records, interview with the DOC and the licensee's pain management policy. [571]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108

Dealing with complaints

s. 108.

The licensee failed to ensure that when a verbal complaint was received by RPN #120 and RN # 121 made by the family of a resident, concerning the care of the resident, the complaint was dealt with including: immediately investigated; responded to within 10 business days, with a date that the family could expect a resolution; a response including what had been done to resolve the complaint; documentation of the complaint so it could be reviewed and analyzed; and immediately report the complaint to the Director.

Rationale and Summary:

Complaints from the family of a resident were received by the Director related to provision of care of the resident.

A resident was injured related to how they were positioned in bed. The family verbalized to an RPN and RN that they were not happy about the care provided to the resident.

The family also spoke to the DOC two weeks later about their concerns related to care of the resident. The concerns were not immediately investigated.

Failing to ensure that verbal complaints received at the home concerning care of a resident were immediately dealt with, minimized the licensee's ability to investigate and respond to the family member within 10 days of being received.

Sources: Family complaint received by the Director, Review of the progress notes of the identified resident, interview with staff. (RPN #120, RN #121 and DOC). [194]

2. The licensee failed to ensure that when the family of a resident made a verbal complaint regarding the care of the resident, the complaint was dealt with including: immediately investigated; responded to within 10 business days, with a date that the substitute decision maker (SDM) could expect a resolution; a response including what has been done to resolve the complaint; documentation of the complaint so it could be reviewed and analyzed; and immediately reporting the complaint to the Director.

Rationale and Summary:

The family members of a resident met with the Clinical Coordinator (CC) #136 and the Director of Care-Quality (DOCQ) #139 to discuss concerns the family had with improper care being provided to the resident.

CC #136 indicated that they could not find their notes related to the meeting or recall the details of the complaint and were unable to recall if an investigation was conducted.

The licensee's complaint log was reviewed. Documentation of the complaint or investigation was not found.

By failing to investigate, respond, report to the Director and keep records of the complaint and investigation for analysis, the licensee placed residents at risk of harm by failing to identify if improper care was provided and if there were trends of allegations of improper care.

Sources: resident's clinical health records, interview with CC #136, review of complaint log. [571]

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