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

Public Report

Report Issue Date: April 2, 2025

Inspection Number: 2025-1088-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Peterborough, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-14, 17-20, 24-27, 2025. The inspection occurred offsite on the following date(s): March 21, 2025.
The following intake(s) were inspected:

- An intake related to a disease outbreak.
- An intake related to the fall of a resident.
- An intake related to a complaint regarding skin and wound of a resident.
- An intake related to resident to resident abuse.
- An intake related to a medical event of a resident.
- An intake related to resident to resident abuse.
- An intake related to a medical event of a resident.
- An intake related to a medical event of a resident.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee had failed to ensure a resident's care plan was revised once their care needs had changed.

The Director was informed of an incident involving a resident. A review of the resident's care plan at the time of the incident indicated an intervention was to be implemented. During an interview with a Registered Practical Nurse (RPN) they indicated that at the time of the incident, the intervention was discontinued. The Director of Care Quality (DOCQ) confirmed that the resident's care plan should have been revised to reflect the change in their care.

Sources: A Critical Incident Report (CIR), a resident clinical records and interviews with a RPN and the DOCQ.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee had failed to immediately report an allegation of resident to resident abuse.

The incident occurred on a specified date, and the After-Hours Line was notified a day after the incident occurred. A CIR was subsequently submitted two days after. The DOCQ confirmed that the incident involving both residents should have been immediately reported to the Director.

Sources: The home's internal policy, a CIR, and interview with the DOCQ.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On a tour of the home, a housekeeper was observed demonstrating the

concentration test for the home's disinfectant product.

During an interview with the housekeeper they indicated that concentration testing should be completed weekly and once a new bottle of the product was placed in the J-fill dispenser. The housekeeper indicated that the bottles in the J-fill dispenser are changed every five to six days and the results of the tests are to be documented on a sheet titled "AHP 1750 test strips testing results". On further review of documentation there was indication that a new bottle of disinfectant was replaced during a specific month with no concentration testing completed. The housekeeper confirmed that no concentration testing was completed for the new bottle of disinfectant replaced.

Sources: Concentration testing documentation and interview with a housekeeper.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

One of the home's internal policies, that was provided to the inspector was last reviewed on a specified dated, and is to be reviewed annually for the required program.

Sources: The home's internal policy and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee had failed to ensure that a resident's behaviours were evaluated and analyzed.

A CIR was submitted involving resident to resident abuse. During a review of a resident's clinical records, an assessment was initiated. A component of the assessment was incomplete.

The DOCQ confirmed that the results of the assessment was to be evaluated and as a result necessary changes to the resident's care needs were to be made.

Sources: A resident's clinical records and interview with DOCQ.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022". IPAC Standard, 9.1 (d), the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, specifically, the proper use of PPE, including application, selection and removal.

During the inspection, it was observed that a Personal Support Worker (PSW) was in a resident room with additional precaution measures in place. A PSW was inside the room with only a medical mask on while speaking to the resident on additional precautions. The PSW confirmed they were not wearing proper Personal Protective Equipment (PPE) as indicated by the IPAC precaution sign and the IPAC Lead confirmed that all staff are to abide by IPAC precaution signage.

Sources: Observations of resident room signage and the PSW, interviews with PSW and IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection

(2); and

The licensee failed to ensure that a resident's symptoms were documented and monitored on every shift.

A CIR was submitted related to a disease outbreak. After review of documentation related to the outbreak, a resident presented with symptoms on a specified dated. A review of the clinical records indicated missing documentation related to symptom monitoring for the resident on a number of days.

Sources: Outbreak documentation, a resident's clinical records and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A number of Critical Incidents were received that involved a medical event of a resident requiring the administration of a medication. The Registered Nurse (RN) on duty, provided the medication several times on multiple days. In each incident the resident was transferred by ambulance to the hospital. The physicians' order does not indicate the frequency in which the medication should be administered.

A product monograph for the medication indicated that the medication should be administered once, with other interventions to be implemented after the initial

administration. The product monograph also specifies symptoms of an overdose.

Sources: Multiple CIR's, product monograph, a resident's clinical records, interviews with physician, DOC, and RN.

COMPLIANCE ORDER CO #001 Plan of care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The license shall:
1. The DOC or designate will educate all RPN's working on a unit, on an intervention. The education will include how the intervention operates, signs and symptoms to monitor the intervention, how to complete a task associated with this intervention, and measures to take if the intervention is not functioning appropriately.
2. The DOC or designate will review the Plan of Care for the identified resident for all PSW's and Registered Staff on a unit to ensure the care is being provided to the resident. The DOC or designate shall document and maintain a written record of the Plan of Care review provided, the dates the Plan of Care review was provided, the staff members that attended, along with signatures of the staff members acknowledging their understanding of the Plan of Care review they received, and the individual that provided the Plan of Care review. This documentation will be provided to the inspector upon request.

Grounds

1. A complaint was received to the Director involving an intervention for a resident. A review of the resident's clinical records indicated that the staff were to perform a task associated with the intervention. On further review of the resident's clinical records, there was no indication that the task was completed during a number of days. During an interview with a RN, they confirmed that the intervention was not completed.

Failing to ensure the tasks associated with the intervention, placed an increased risk to the resident's health.

Sources: A resident's clinical records and interview with RN and DOC.

2. A Critical Incident was submitted to the Director concerning the fall of resident with a transfer to hospital. A PSW confirmed that they were unfamiliar with the resident and did not check the plan of care that advised specific information related to a task. A PSW moved the resident resulting in the resident falling.

Sources: A CIR, resident's plan of care, interview with a PSW.

This order must be complied with by May 23, 2025

COMPLIANCE ORDER CO #002 CMOH and MOH

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. The IPAC Lead or designate shall provide education to each housekeeper in the Support Services Department, on the home's cleaning and disinfecting practices, including but not limited to the frequency of cleaning and disinfecting high touch surfaces when a resident home area is in an outbreak.
2. The IPAC Lead or designate shall document and maintain a written record of the education provided, the dates the education was provided, the staff members that attended the education, signatures of the staff members acknowledging their understanding of the education they received, and the individual that completed the education session.
3. The IPAC Lead and Support Services Manager (SSM) will collaborate to develop and implement a checklist for staff in the Support Services Department to utilize and ensure high touch surfaces are cleaned, when resident home areas are in a confirmed outbreak.
4. The IPAC Lead and SSM will keep a copy of the implemented checklist and make it available to Inspectors upon request.

Grounds

The license failed to ensure that recommendations issued by the Chief Medical Officer of Health were followed. Specifically, the Ministry of Health's "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, 2024", effective October 2024 section 3.12 states that cleaning and disinfecting of high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas, should be at minimum twice daily.

During an interview with two housekeepers, they confirmed that during an outbreak,

high touch surfaces are cleaned and disinfected once daily. The housekeeper confirmed that a resident home area was in a confirmed outbreak.

The home's IPAC Lead and SSM confirmed that the expectation is that high touch surfaces are to be cleaned and disinfected twice daily.

Failing to ensure high touch surfaces were cleaned and disinfected twice daily during an outbreak, posed an increased risk of the spread of infectious agents.

Sources: The home's internal policy, interviews with two housekeepers, IPAC Lead and SSM.

This order must be complied with by May 23, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.