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: November 21, 2023
Inspection Number: 2023-1379-0006
Inspection Type: Proactive Compliance Inspection (PCI)
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Bay Ridges, Pickering

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2023.11.22 12:14:04 -05'00'

Additional Inspector(s)
Catherine Ochnik (704957)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 17 – 20 and 23 - 25, 2023.

The following intake(s) were inspected:

- Intake: #00099328 - Bay Ridges PCI

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, the licensee failed to ensure the implementation of additional requirement 6.1 under the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard): The licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

Summary and Rationale

On a specific date, the Director of Care (DOC) communicated to the inspectors that universal masking was to be immediately implemented in the long-term care (LTC) home as a precautionary measure. A sign was posted at the entry to the building stating, "STOP Surgical mask is required to enter this facility."

The following day, there were no masks available at the entry to the long-term care home. When the inspector brought it to the attention of the staff member seated at the front desk, the staff member obtained two boxes of surgical masks and placed them on a table in the entry vestibule.

The Director of Care (DOC) acknowledged that not enough surgical masks were placed at the entry to the home and indicated that the staff should replenish the masks. The IPAC Manager also indicated that any staff could replenish the surgical masks at the entry of the building from the supply cupboard.

During observations of two resident rooms in two different home areas, it was noted that additional precautions were in place and there were no gowns in the PPE caddies hanging at the entry doors of the rooms. The resident rooms both had signs on the doors indicating Contact Precautions were in place and signs with instructions for donning and doffing PPE. Both rooms had PPE caddies hanging on the doors, and both had no gowns in the PPE caddies.

In an interview, the IPAC Manager indicated that it was the responsibility of the after-hours Environmental Services Manager, however all front-line staff could replenish the PPE caddies and that it was an expectation for the PPE to be restocked and available.

Failing to ensure access to surgical masks at the entry to the building when universal masking was in place, and failing to ensure that the PPE caddies were restocked at the rooms of residents on additional precautions increased risk of transmission of infection.

Sources: Signage posted at entry to LTC Home, interviews with DOC and IPAC Manager, observations.

[706026]