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: February 6, 2023	
Inspection Number: 2023-1336-0002	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Cobourg, Cobourg	
Lead Inspector Deborah Nazareth (741745)	**Inspector Digital Signature** Deborah A Nazareth Digitally signed by Deborah A Nazareth Date: 2023.02.13 14:40:33 -05'00'
Additional Inspector(s) Sarah Gillis (623) Najat Mahmoud (741773)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 16-20, 2023

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00002504 – was related to falls prevention and management.
- Intake: #00002698 – was related to responsive behaviors.

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

Infection Prevention and Control
Falls Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 59 (b)

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Rationale and Summary

A critical incident report (CIR) was submitted by the home and indicated that an altercation took place between two residents, which resulted in an injury.

Resident #002 and #003's clinical records indicated specific responsive behaviors were identified which included triggers and interventions for both residents.

Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) #109 confirmed that resident #002 required specific interventions to ensure resident safety. BSO RPN indicated they reviewed the video footage of the incident and interventions were not followed.

PSW #112 stated that when the incident occurred, the two residents were unsupervised and that it was difficult to implement the identified interventions since staff were unavailable.

Failure to implement identified interventions to monitor resident #002 resulted in an altercation between residents #002 and #003. As a result, resident #003 sustained an injury.

Sources: CIR, resident #002 and #003's clinical records, interviews with staff.
[741773]

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee has failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.

2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

1) During the inspection, housekeeper #110 was observed exiting a staff break room wearing gloves in the hallway as they transported their housekeeping cart. Interview with housekeeper #110 stated they remove their used gloves, complete hand hygiene with hand sanitizer, don a new pair of gloves and perform hand hygiene with hand sanitizer over the gloves when they leave a room they have cleaned. The Housekeeper was asked about cleaning products used in the home and was unaware of the required contact time for disinfecting. Review of housekeeper #110's education status report revealed they had not completed mandatory training before working in the home and had just been enrolled in the program at the start of January 2023. Infection Prevention and Control (IPAC) Lead and Environmental Services Manager (ESM) confirmed that housekeeper #110 was hired two months prior, and they did not receive mandatory training prior to performing their responsibilities in the home.

When housekeeper #110 did not receive mandatory training as outlined in section 82 (2) of the Act and was not aware of the responsibilities of their role related to infection prevention and control including hand hygiene, cleaning and disinfecting, there was an increased risk for the spread of infection throughout the home.

Sources: Observations, interviews with housekeeper #110, IPAC Lead, and ESM, education status report of housekeeper #110.
[741745]

2) Agency Registered Nurse (RN) #102 began working in the home as charge nurse in June 2022. RN #102 reported they did not receive training prior to starting their work in the home. IPAC Lead confirmed that RN #102 did not receive mandatory training in accordance with section 82 (2) of the Fixing Long-Term Care Act and there was no record of training or orientation for RN #102 in the home. RN #102 continues to work in the home.

When agency RN #102 did not receive mandatory training prior to working, they were not aware of all of their responsibilities in the home placing residents at risk.

Sources: Interviews with RN #102 and IPAC Lead, review of training records and agency files. [741745]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

1) Non-compliance with: FLTCA, 2021 s. 184 (3)

The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they failed to follow the COVID-19 asymptomatic screen testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective December 23, 2022.

Rationale and Summary

The procedure card of the Rapid Response COVID-19 Antigen Rapid Test Device, which was used in the home to test general visitors, caregivers, and staff, prior to entering the home, indicated the test swab should stand in the solution for two minutes prior to adding three drops to the well of the test device and results of the test should be read at 15 minutes.

During observation of the screening/testing area, a visitor was observed being tested using the Rapid Response Covid-19 Antigen Rapid Test Device. The test swab was not left in the solution for two minutes prior to the solution being added to the test well and the visitor was allowed to enter the resident home area after waiting only five minutes. The test device was discarded after the visitor proceeded to the home area and was not read at 15 minutes.

Interview with screener #104 indicated they read the test results after seven to eight minutes and consider it negative if they do not see any smudge or faint line on the "T-line". Screener #104 confirmed the expected time to read the test was at 15 minutes. The IPAC Lead indicated the expectation for performing the Covid-19 antigen rapid test was to follow the manufacturer's instructions and acknowledged it was important to follow the manufacturer's instructions as positive Covid-19 results could potentially be missed.

By failing to follow the manufacturer's instruction as outlined on the procedure card, the test performance may have been adversely affected and test results invalid, resulting in the potential spread of Covid-19 infection.

Sources: Observations of screening/testing area, review of the home's Covid-19 testing log, Rapid Response Procedure Card Covid-19 Antigen Test Device, interviews with screener #104 and IPAC Lead. [741745]

2) Non-compliance with: FLTCA, 2021 s. 184 (3)

The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they failed to follow the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective December 23, 2022.

Rationale and Summary

In accordance with the Covid-19 Guidance Document for Long-Term Care Homes in Ontario, last updated December 23, 2022, homes must ensure that all staff comply with masking requirements at all times even when they are not delivering direct patient care, including in administrative areas.

On multiple dates during the inspection, multiple staff were observed with their mask below their nose or chin or not wearing a mask, with others present in the surrounding, including residents. IPAC Lead confirmed that universal masking was in place and staff were to only remove their mask in designated areas.

Failure to ensure masking requirements were followed could lead to transmission of infection.

Sources: Observations of public spaces in the home, interview with IPAC Lead.
[741745]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

1) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 9.1 (e)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the Infection Prevention and Control program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022" (IPAC Standard). Specifically, the licensee did not ensure that point-of-care signage indicating that enhanced IPAC control measures were in place as required by Additional Requirement 9.1 Additional Precautions (e) under the IPAC Standard.

Observations in the home identified, point-of-care signage indicating that enhanced IPAC measures were required, was missing from two resident rooms. Resident #004 required additional contact precautions as identified in their care plan. While there was a personal protective equipment (PPE) cart outside the door, there was no signage to indicate what additional precautions were needed for those entering the room. Resident #005 was observed to be using a medical device, which is considered an aerosol-generating medical procedure (AGMP) and may require additional contact and droplet precautions. There was no signage identifying an AGMP and there was no PPE available at point-of-care to indicate what enhanced IPAC control measures were in place.

Interview with IPAC Lead confirmed there should have been signage on the doors of the two resident rooms indicating enhanced IPAC control measures were in place. The IPAC Lead replaced these signs.

When point-of-care signage indicating that enhanced IPAC control measures were required was missing, there was risk of harm to residents and staff from possible transmission of infectious agents.

Sources: Observations, interview with IPAC Lead, plan of care for residents #004 and #005.
[741745]

2) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 6.1

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

In accordance with Additional Requirement 6.1 under the IPAC Standard the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk.

A PPE cart was observed outside of a resident room, who was identified as requiring contact precautions. The cart did not contain all necessary PPE for staff to perform care, specifically gowns were missing. Resident #005 utilized a medical device that was considered an AGMP, which may require additional contact and droplet precautions; there was no PPE available able at point-of-care for staff to use. IPAC Lead confirmed that PPE should have been available outside of both resident rooms.

As a result of not having PPE available and accessible to staff there was a risk of harm to residents and staff from possible transmission of infectious agents.

Sources: Observations, interview with IPAC Lead, plan of care for residents #004 and #005, document CRG-02_A10-AGMP-in-Progress-Precautionary-Sign.
[741745]

3) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 5.4 (g)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

In accordance with Additional Requirement 5.4 (g) under the IPAC Standard the licensee shall ensure that the policies and procedures for the IPAC program also address IPAC related practices for aerosol generating medical procedures (AGMPs).

Resident #005 was observed using a medical device, which is considered an AGMP, that may require additional contact and droplet precautions including use of an N95 mask. Interview with IPAC Lead revealed the home did not have written policies and procedures that addressed IPAC related practices for AGMPs and instead utilized a point-of-care sign that was to be always on the resident's room door.

At the time of observation there was no signage on the door or PPE available for this AGMP.

By not having policies and procedures in place that addressed IPAC related practices for AGMPs there was a risk staff would not know what precautions to implement and a risk to residents and other staff from possible transmission of respiratory infections.

Sources: Observations, interview with IPAC Lead, plan of care for resident #005, document CRG-02_A10-AGMP-in-Progress-Precautionary-Sign.
[741745]

WRITTEN NOTIFICATION: Orientation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 259 (2)

1) Non-compliance with: O. Reg. 246/22 s. 259 (2) (a)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes hand hygiene.

Rationale and Summary

Housekeeper #110 was observed wearing gloves in the hallway, when asked about the gloves, they stated they remove their gloves and perform hand hygiene, then don a new pair of gloves and perform hand hygiene over the gloves before they leave the room they cleaned. Review of housekeeper #110's education status record indicated that they had not completed their training module titled "Extendicare IPAC: Module 2 Hand Hygiene (A Safe Pair of Hands)". IPAC Lead and ESM confirmed that housekeeper #110 was hired two months prior. The housekeeper had not completed training prior to performing their responsibilities in the home and had not completed hand hygiene training as of the time of inspection.

When housekeeper #110 did not receive training in IPAC including hand hygiene, they were placing residents at risk for transmission of infection.

Sources: Observations, interviews with housekeeper #110, IPAC Lead and ESM, and education status report of housekeeper #110.
[741745]

2) Non-compliance with: O. Reg. 246/22 s. 259 (2) (f)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes cleaning and disinfection practices.

Rationale and Summary

During an interview, housekeeper #110 was asked which cleaning products were used in the home and was unaware of the required contact time for proper disinfecting. Review of housekeeper #110's education status record indicated they had not completed their training module titled "Extendicare IPAC: Module 4 Cleaning and Disinfecting". IPAC Lead and ESM confirmed that housekeeper #110 was hired two months prior and has not completed IPAC training specific to cleaning and disinfection, which directly relates to their responsibilities as a housekeeper in the home.

When housekeeper #110 did not receive training in IPAC cleaning and disinfecting, they were not aware of the responsibilities of their role related to infection prevention and control placing residents at risk for the transmission of infection.

Sources: Observations, interviews with housekeeper #110, IPAC Lead and ESM, and education status report of housekeeper #110.
[741745]

3) Non-compliance with: O. Reg. 246/22 s. 259 (2) (g)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes use of personal protective equipment including appropriate donning and doffing.

Rationale and Summary

Housekeeper #110 was observed wearing gloves in the hallway as they transported their housekeeping cart. Review of housekeeper #110's education status record indicated that they had not completed their training module titled "Extendicare IPAC: Module 3 Routine Practices". IPAC Lead stated that gloves should not be worn in the hall and confirmed that housekeeper #110 was hired two months prior did not complete training prior to performing their responsibilities in the home.

When housekeeper #110 did not receive training in IPAC Routine Practices, they were not aware of the

responsibilities of their role related to infection prevention and control placing residents at risk for the transmission of infection.

Sources: Observations, interviews with housekeeper #110, IPAC Lead and ESM, and education status report of housekeeper #110.
[741745]