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

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Original Public Report

Report Issue Date: January 11, 2024
Inspection Number: 2023-1336-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Cobourg, Cobourg

Lead Inspector	**Inspector Digital Signature**
Sami Jarour (570)	Sami Jarour Digitally signed by Sami Jarour Date: 2024.01.25 15:22:22 -05'00'

Additional Inspector(s) Chantal Lafreniere (194)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 6, 7, 8, 11, 12, 14, 15, 18, 2023

The following intake(s) were inspected:

- Intake: #00102745 - PCI inspection Extendicare Cobourg

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Rationale and Summary

During the initial tour of the PCI inspection, Inspectors #570 and #194 tested the call bell system in a resident's room. The call bell system was not activated when tested. Staff #100 confirmed the call bell system was not activated and that they would replace the call bell cord.

By not maintaining the call bell system in good repair, residents' safety was put at risk.

Sources: Inspector's observations; interview with staff #100. [570]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
Documentation
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee has failed to document the actions taken to improve the home based on the results of the satisfaction survey.

Rationale and Summary

The licensee's Resident and Family satisfaction survey was completed for 2022. The Administrator confirmed that a documented action plan based on the results of the

satisfaction survey had not been completed.

Failing to ensure that there is a documented action plan based on the home's satisfaction survey, provided a missed opportunity for the home to meet resident and family expectations.

Sources: Resident and Family satisfaction survey 2022, Resident Council Meeting Minutes August 15, 2023, Interviews with staff. (Administrator and DOCQ). [194]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (c)
Resident and Family/Caregiver Experience Survey
Documentation
s. 43 (5) The licensee shall ensure that,
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and

The licensee has failed to document the actions taken to improve the home based on the results of the satisfaction survey.

Rationale and Summary

The licensee's Resident and Family satisfaction survey was completed for 2022. The Administrator confirmed that a documented action plan based on the results of the satisfaction survey had not been completed.

Failing to ensure that there is a documented action plan based on the home's satisfaction survey, provided a missed opportunity for the home to meet resident and family expectations.

Sources: Resident and Family satisfaction survey 2022, Resident Council Meeting Minutes August 15, 2023, Interviews with staff. (Administrator and DOCQ). [194]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (d)
Resident and Family/Caregiver Experience Survey
Documentation
s. 43 (5) The licensee shall ensure that,
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part X.

The licensee has failed to document the actions taken to improve the home based on the results of the satisfaction survey.

Rationale and Summary

The licensee's Resident and Family satisfaction survey was completed for 2022. The Administrator confirmed that a documented action plan based on the results of the satisfaction survey had not been completed.

Failing to ensure that there is a documented action plan based on the home's satisfaction survey, provided a missed opportunity for the home to meet resident

and family expectations.

Sources: Resident and Family satisfaction survey 2022, Resident Council Meeting Minutes August 15, 2023, Interviews with staff. (Administrator and DOCQ). [194]

WRITTEN NOTIFICATION: POWERS OF RESIDENTS' COUNCIL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
Duty to respond
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond in writing to the Resident Council within 10 days after receiving a concern.

Rationale and Summary

The Resident Council Meeting minutes identified several concerns. The Program Manager (PM). The PM confirmed that the response was not provided to the Resident Council within 10 days.

The Administrator confirmed that a specified concern should have been completed in a formal manner, with a concern form being completed and a written response provided to the Resident Council.

Failing to respond in writing to the Resident Council within 10 days after receiving a

concern, increases the potential for ongoing risk in the home.

Sources: Resident Council meeting minutes, interview with staff. (Program Manager and Administrator). [194]

WRITTEN NOTIFICATION: FAMILY COUNCIL

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
Licensee obligations if no Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to convene semi-annual meetings to advise such persons of the right to establish a Family Council.

Rationale and Summary

During Proactive Compliance Inspection (PCI) the Program Manager (PM) confirmed that the home did not convene semi-annual meetings to advise families of the right to establish a family council in the home. PM confirmed that the home's newsletter did not advise families of the right to establish a Family Council.

The Administrator confirmed that a Virtual Town hall meeting was scheduled on a specified date. A review of the agenda for the meeting was completed and did not advise families of the right to establish a family council at the home. The Administrator confirmed that no there was no attendance at the virtual Town hall

meeting from any of the families.

A review of the home's Family Council policy confirmed that a semi-annual meeting was to be established to advise the importance and their right to a Council.

Failing to convene semi-annual meetings to advise families of the right to establish a Family Council, limits the potential to establish a Family Council at the home, where thoughts, concerns and ideas for the residents can be discussed.

Sources: review of the home's Family Council Policy and Interview with staff (Program Manager and Administrator). [194]

WRITTEN NOTIFICATION: RETRAINING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
Retraining
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure staff #101 received training at annual intervals on the home's infection prevention and control (IPAC).

In accordance with FLTCA s. 82 (2) 9 the licensee is required to ensure that staff receive training on the home's infection prevention and control (IPAC) at orientation and specifically, as per O. Reg 246/22 s, 260 (1) the training must be completed at annual intervals.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #101 indicated they did not complete the annual training in Extendicare IPAC, specifically Extendicare IPAC: Module 3, Routine Practices with a due date of March 31, 2022, and Extendicare IPAC: Module 4, Cleaning and Disinfecting with a due date of March 31, 2022. The 2023 report of December 11, 2023, identified staff #101 did not complete the four modules of Extendicare IPAC with due dates of March 31, 2023.

The DOC Quality/IPAC lead confirmed that staff #101 did not complete two out of the four modules related to IPAC in 2022 and had not completed the IPAC training in 2023.

Failure to retrain direct care staff on an annual basis, staff may not be aware of new requirements and updates related to IPAC putting residents at risk of receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's

specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure high touch surfaces were cleaned more than once daily in accordance with evidence-based practices when a residents' home area was in an outbreak.

According to Public Health Ontario's Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings, high touched and frequently touched surfaces should be cleaned and disinfected at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

Rationale and Summary

On December 13, 2023, the LTC home went into an outbreak. During an observation of the outbreak residents' home area, staff #121 was interviewed and indicated they only clean high touch surfaces once a day and that does not change during outbreak situations.

A review of the Extendicare Cobourg Deep Cleaning Check List (Common Areas) Hallway Railings, Light Switches, Keypads and Doorknobs for an identified period, indicated high touch surfaces were cleaned once daily with no change in cleaning frequency before and during the outbreak in the Pine residents' home area.

An interview with the Environmental Manager indicated high touch contact surfaces should be cleaned more frequently (twice daily) when there is an outbreak and staff

are doing the best they can, some days are missed when short-staffed.

Failure to clean and disinfect high touch surfaces in a home area that is in an outbreak could contribute to the spread of infectious agents.

Sources: Public Health Ontario, COVID-19 Key Elements of Environmental Cleaning in Healthcare Settings, the Extendicare Cobourg deep cleaning checklist, interviews with staff #121 and the Environmental Manager. [570]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times.

Rationale and Summary

During observations in Pine residents' home area, Inspector #570 noted that a SPA room door was unlocked. Three containers of All Purpose Disinfectant Cleaner were stored in an unlocked bottom cupboard in the SPA room. The labels on containers indicated danger - corrosive to eyes, skin irritant and poison.

Staff #112 confirmed the storage of All Purpose Disinfectant Cleaners in an unlocked

bottom cupboard and indicated that the SPA room door should be locked for safety concerns for residents.

The Director of Care – Quality (DOC-Q) indicated that disinfectants are stored in the nursing supply room in a residents' home area and in the bottom cupboard in the SPA room. The DOC-Q indicated a reminder went out to all staff to keep SPA rooms locked.

Failure to ensure that hazardous substances were stored in areas inaccessible to residents, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Inspector's observations, interviews with staff #112 and DOC-Quality. [570]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure that the Medical Director was part of the Continuous quality improvement committee.

Rationale and Summary

The Administrator confirmed that the Medical Director was not included in the Continuous Quality Improvement Committee (CQI) meetings. A review of the CQI meeting minutes dated July 26, 2023, confirmed that the Medical Director did not attend the meetings.

Failing to ensure that the Medical Director is on the (CQI) meetings, limits their ability to provide feedback on improvements at the home.

Sources: Review of the CQI meeting minutes and interview with staff. (Administrator, DOCQ). [194]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the Registered Dietitian was part of the Continuous Quality Improvement committee.

Rationale and Summary

The Administrator and Registered Dietitian (RD) confirmed that the RD was not a member of the Continuous Quality Improvement Committee (CQI) meetings. A review of the CQI meeting minutes dated July 26, 2023, confirmed that the RD did

not attend the meetings.

Failing to ensure that the RD is a member of the (CQI) meetings, limits their ability to provide feedback on improvements at the home.

Sources: Review of the CQI meeting minutes and interview with staff. (Administrator, Dietitian). [194]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that the Pharmacy provider was a member of the Continuous Quality improvement committee.

Rationale and Summary

The Administrator confirmed that the Pharmacy provider was not a member of the Continuous Quality Improvement (CQI) Committee. A review of the CQI meeting minutes dated July 26, 2023, confirmed that the Pharmacy provider did not attend the meetings.

Failing to ensure that the Pharmacy provider is on the (CQI) meetings, limits their ability to provide feedback on improvements at the home.

Sources: Review of the CQI meeting minutes and interview with staff. (Administrator) [194]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to include in their Continuous Quality Improvement Initiative report for the home posted on the licensee's website, the date of the Resident and Family survey, the results of the survey and the action taken during the fiscal year to address the survey.

Rationale and Summary

The home's Continuous Quality Improvement Initiative (CQI) report posted on the licensee's website was reviewed. The CQI report did not have the following information; the date of the Resident and Family survey, the results of the survey and the action taken during the fiscal year to address the survey.

The Administrator confirmed that the Continuous Quality Improvement Initiative (CQI) report posted on the licensee's website did not have the date of the Resident and Family survey, the results of the survey or the actions taken to address the survey.

Failing to ensure that the home posts all key information on the website related to their CQI report, limits the family, visitors and community members' knowledge of the home's quality improvements at the home.

Sources: Review of the CQI report posted on the home's website, 2022 Resident and Family satisfaction survey and interview with staff. (Administrator and DOCQ). [194]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services,

programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the CQI report posted on the website listed the dates the actions from the Resident and Family Satisfaction survey were implemented as well as the outcomes of the actions.

Rationale and Summary

The home's Continuous Quality Improvement Initiative (CQI) report posted on the licensee's website was reviewed. The CQI report did not include; the dates of the survey, when the actions from the Resident and Family Satisfaction survey were implemented as well as the outcomes of the actions.

The Administrator confirmed that the Continuous Quality Improvement Initiative (CQI) report posted on the licensee's website did not include the dates when the actions from the Resident and Family Satisfaction survey were implemented as well as the outcomes of the actions.

Failing to ensure that the home posts all key information on the website related to their CQI report, limits the family, visitors and community members' knowledge of the home's quality improvements at the home.

Sources: Review of the CQI report posted on the home's website, 2022 Resident and Family satisfaction survey and interview with staff. (Administrator and DOCQ). [194]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY

IMPROVEMENT INITIATIVE REPORT

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iv.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

The licensee has failed to ensure that the CQI report posted on the website included the role of the CQI committee in actions taken to address the concerns identified related to the Resident and Family satisfaction survey.

Rationale and Summary

The home's Continuous Quality Improvement Initiative (CQI) report posted on the licensee's website was reviewed. The CQI report did not include the role of the CQI committee, in actions taken to address the concerns identified related to the Resident and Family satisfaction survey

The Administrator confirmed that the Continuous Quality Improvement Initiative (CQI) report posted on the licensee's website did not include the role of the CQI committee in actions taken to address the concerns identified related to the Resident and Family satisfaction survey.

Failing to ensure that the home posts all key information on the website related to their CQI report, limits the family, visitors and community members' knowledge of

the home's quality improvements at the home.

Sources: Review of the CQI report posted on the home's website, 2022 Resident and Family satisfaction survey and interview with staff. (Administrator and DOCQ). [194]

WRITTEN NOTIFICATION: TRAINING AND ORIENTATION PROGRAM

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (2)
Training and orientation program
s. 257 (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure that, at least annually, the training and orientation program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), the Director of Care – Quality (DOC-Q) indicated they were the designated lead for the home's training and orientation program and that the home uses checklists for PSW and registered staff as part of the program for new staff.

The documentation provided related to the training and orientation program included two checklists for PSW and registered staff. The home was unable to

provide a written record related to the program review and evaluation in 2022 and 2023.

The Administrator and the DOC-Q indicated the evaluation of the training and orientation program was not completed at the home level in 2022 and 2023.

Failure to ensure that the training and orientation program was evaluated and updated at least annually, the opportunity to improve the program is lost.

Sources: review of training and orientation checklist, interviews with the Administrator and the DOC-Quality. [570]

WRITTEN NOTIFICATION: RETRAINING

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that staff #110 received retraining at annual intervals.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #110 indicated they did not complete any retraining annually from the dates of completion of the retraining in 2022. The Surge Learning Education Status Report - 2023, identified that they had not completed any retraining as of the report date of December 11,

2023. The Surge Learning Education Status Report - 2022, identified that they had completed retraining on different dates between January 28, 2022, to September 26, 2022. Retraining related to falls prevention and management with a due date of November 30, 2022, had not been completed in 2022.

The Director of Care – Quality (DOC-Q) who is the lead for the training and orientation program indicated that staff #110 had none of their annual retraining completed in 2023 as of the Surge report date of December 11, 2023. The staff had been spoken to and they completed the annual retraining as of December 18, 2023, which was not done within one year from the previous year's retraining due dates in 2022. The DOC-Q confirmed that staff #110 did not complete the retraining on Extendicare Falls Prevention in 2022.

Failure to retrain direct care staff on an annual basis puts residents at risk of receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

1) The licensee failed to ensure that staff #101 received annual training in falls prevention and management.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #101 indicated they did not complete their retraining in falls prevention and management in 2022 and in 2023 as the report date of December 11, 2023.

The DOC-Q confirmed that staff #101 did not complete the retraining on Extendicare Falls Prevention as per the Surge reports.

Failure to retrain direct care staff on an annual basis puts residents at risk of receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

2) The licensee failed to ensure that staff #110 received annual training in falls prevention and management.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #110 indicated they did not complete their retraining in falls prevention and management in 2022 and in 2023 as the date of the 2023 report of December 11, 2023.

The DOC-Q confirmed that staff #110 did not complete the retraining on Extendicare Falls Prevention in 2022.

Failure to retrain direct care staff on an annual basis puts residents at risk of receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee failed to ensure that staff #101 received annual training on skin and wound care.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #101 indicated they did not complete their retraining on Extendicare Skin and Wound in 2022 and in 2023 as the report date of December 11, 2023.

The DOC-Q confirmed that staff #101 did not complete the retraining on Extendicare Skin and Wound management as per the Surge reports.

Failure to retrain direct care staff on an annual basis puts residents at risk of

receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee failed to ensure that staff #101 received annual training in pain management.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #101 indicated they did not complete their retraining in Pain management in 2022 and in 2023 as the report date of December 11, 2023.

The DOC-Q confirmed that staff #101 did not complete the retraining on Extendicare Pain management as per the Surge reports.

Failure to retrain direct care staff on an annual basis puts residents at risk of

receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 5.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

The licensee failed to ensure that staff #101 received annual training in Restraints

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #101 indicated they did not complete their retraining on Restraints in 2022 and in 2023 as the report date of December 11, 2023.

The DOC-Q confirmed that staff #101 did not complete the retraining on Extendicare Restraints and PASDs management as per the Surge reports.

Failure to retrain direct care staff on an annual basis puts residents at risk of

receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 6.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

The licensee failed to ensure that staff #101 received annual training on PASDs.

Rationale and Summary

A review of the Surge Learning Education Status Reports for staff #101 indicated they did not complete their retraining on Restraints and PASDs in 2022 and in 2023 as of the 2023 report date of December 11, 2023.

The DOC-Q confirmed that staff #101 did not complete the retraining on Extendicare Restraints and PASDs as per the Surge reports.

Failure to retrain direct care staff on an annual basis puts residents at risk of receiving improper care and services.

Sources: The home's education records, and an interview with the DOC-Q. [570]

WRITTEN NOTIFICATION: VISITOR POLICY

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (2) (a)
Visitor policy
s. 267 (2) Every licensee of a long-term care home shall maintain visitor logs for a minimum of 30 days which include, at a minimum,
(a) the name and contact information of the visitor;

The licensee has failed to ensure that the visitor log included the contact information of the visitor.

Rationale and Summary

A review of the home's visitors' logs identified that the log did not include the contact information of visitors.

The Administrator acknowledged that the visitor's log did not include the contact information of the visitor.

Failing to collect contact visitor's contact information could impede the LTC home's ability to communicate with visitors.

Sources: A review of visitors' logs and an interview with the Administrator. [570]

COMPLIANCE ORDER CO #001 TRAINING

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
Orientation
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) 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.

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

1) Provide staff #108 with the required orientation training for all subsections listed in FLTCA, 2021, s. 82 (2).

2) Provide staff #112 with the required orientation training for all subsections listed in FLTCA, 2021, s. 82 (2).
3) Provide staff #113 with the required orientation training for all subsections listed in FLTCA, 2021, s. 82 (2).
4) Complete an audit of the orientation training of all staff hired from May 1, 2023, to the time this inspection report is served. For any staff member identified to have not completed the required orientation training in FLTCA, 2021, s. 82 (2), complete the required training immediately.

A written record must be kept of everything required under (1), (2), and (3), until the Ministry of Long-Term Care has determined the licensee has complied with this order.

Grounds
1) The licensee has failed to ensure staff #108 received training in the required areas, prior to performing their responsibilities.

Rationale and Summary

Staff #108 confirmed they started working at the home in October 2023, received orientation and had completed their Zero Tolerance of Abuse in SURGE learning. The Operation Manager confirmed that staff #108 was hired on September 18, 2023.

The Director of Care (DOC) Quality, confirmed that staff #108's first shift in the home was October 5, 2023, and that the educational requirements in SURGE learning had not been completed prior to performing their responsibilities.

A review of staff #108's educational records in SURGE Learning were completed and confirmed that none of the required modules had been completed prior to

performing their responsibilities.

Failing to ensure that staff #108 at the home received required education prior to performing their responsibilities, increases the risk to residents' safety.

Sources: Review of education records and interviews with Operation Manager, DOCQ, and staff #108 [194]

2) The licensee has failed to ensure staff #113 received training in the required areas, prior to performing their responsibilities.

Rationale and Summary

A review of the Surge Learning Education Status Report - 2023, for staff #113 identified that staff #113 started the training on June 24, 2023, and had not completed training related to the home's mission statement, residents rights, restraints policy, zero tolerance of abuse and neglect policy has not been completed before starting job duties until the date of the report on December 11, 2023.

A review of the home's staff schedule provided by the Environmental Manager identified that staff #113 was scheduled to work on June 13, 2023.

The Director of Care (DOC) Quality, confirmed staff #113 was hired on May 20, 2023. The DOC-Q acknowledged they had not completed the required training before June 13, 2023.

Failing to ensure that Housekeeping staff received required education prior to performing their responsibilities, increases the risk to residents' safety.

Sources: Surge Learning Education Report; staff schedule and interview with the DOC-Q. [570]

3) The licensee failed to ensure staff #112 received training in the required areas, prior to performing their responsibilities.

Rationale and Summary

Staff #112 indicated they had not completed any training upon their return to the home including IPAC training as they were busy working on the floor.

A review of the Surge Learning Education Status Report - 2023, for staff #112, identified they had not completed any training.

The Director of Care (DOC) Quality, indicated staff #112 was rehired at the home and started their first shift on July 24, 2023. The DOC-Q confirmed they had not completed the required training prior to performing their responsibilities.

Failing to ensure that staff at the home received required education prior to performing their responsibilities, increases the risk to resident safety.

Sources: Surge Learning Education Report; interview with staff #112 and the DOC-Q. [570]

This order must be complied with by April 30, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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).

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

1) Educate staff #110 on the 4 moments of hand hygiene.
2) Educate staff #110 on the proper use of personal protective equipment (PPE).
3) Test staff #110's knowledge related to the 4 moments of hand hygiene and use of PPE.
4) Conduct daily audits of snack services for one week in all residents' home areas to ensure staff serving residents follow the home's hand hygiene program and for proper use of PPE during snack services as required.

A written record must be kept of everything required under (1), (2), (3) and (4) until the Ministry of Long-Term Care has determined the licensee has complied with this order.

Grounds
The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented; specifically, the licensee has failed to ensure that staff performed hand hygiene at the moments required.

Rationale and Summary

According to 9.1 b) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices were followed in the IPAC program and at a minimum, included hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Satff #110 was observed wearing gloves while serving residents. The staff pushed the service cart, knocked on doors, touched door handles, and picked up empty glasses while wearing the same gloves and without performing hand hygiene during the snack service. During the service, the staff adjusted a resident's eyeglasses before offering the resident a drink while using the same gloves and assisted another resident while wearing the same gloves.

Staff #110 indicated they put the gloves on before starting the service and they did not remove the gloves until after the service was completed. The staff indicated they were told to use gloves when they first started at the home and were unaware if that had changed. Staff #110 indicated they should have taken the gloves off and hand sanitized each time.

The IPAC lead indicated that staff are expected to follow the 4 moments of hand hygiene, before and after resident care, in between tasks, and before entering the LTC environment; Staff should not wear gloves when giving snacks to residents; gloves are worn when providing personal care to residents and doff gloves after each use and perform hand hygiene; staff shouldn't be moving from one resident's room to another resident's room while wearing the same gloves.

There was a risk of spreading infectious diseases to residents in the home when staff #110 did not follow routine practices by not performing hand hygiene as required.

Sources: Inspector #570's observations; review of Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, and interviews with staff #110 the IPAC lead. [570]

This order must be complied with by March 31, 2024

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.