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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 18, 2024
Original Report Issue Date: April 3, 2024
Inspection Number: 2024-1336-0001 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Cobourg, Cobourg

Amended By Rodolfo Ramon (704757)	**Inspector who Amended Digital Signature** Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2024.05.01 14:51:19 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
-Extend the compliance order due dates (CDD) for Compliance Orders (CO) #001 and #003
-Remove the Director of Care (DOC) as the staff who did not report the incident to reflect that it was the LTC home that did not report the incident.
-Correct a system error in the CDD for COs #004 and #005

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Lead Inspector Rodolfo Ramon (704757)	**Additional Inspector(s)** Tiffany Forde (741746)
Amended By Rodolfo Ramon (704757)	**Inspector who Amended Digital Signature** Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2024.05.01 14:51:44 -04'00'

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-Extend the compliance order due dates (CDD) for Compliance Orders (CO) #001 and #003
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-Correct a system error in the CDD for COs #004 and #005

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 28, 29, 2024 and March 1, 4-7, 2024

The following intake(s) were inspected:

- One was a complaint related to infection prevention and control practices
- One intake was a complaint related to infection prevention and control practices
- One intake was related to a fall with injury
- One intake was related to a disease outbreak
- One intake was related to resident to resident sexual abuse
- One intake was related to resident to resident sexual abuse
- One intake was related to resident to resident abuse
- One intake was a complaint related to infection prevention and control practices
- One intake was related to an unplanned evacuation

The following intakes were completed:

- Three intakes related to a fall with injury

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

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

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training

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 that a Registered Practical Nurse (RPN) received training at annual intervals on the home's policy for Residents' Bill of Rights, to promote zero tolerance of abuse and neglect of residents and Fire prevention and safety.

In accordance with FLTCA s. 82 (2) 1, 3,7 the licensee is required to ensure that staff receive training on the home's Residents' Bill of Rights, to promote zero tolerance of abuse and neglect of residents and Fire prevention and safety and specifically, as per O. Reg 246/22 s, 260 (1) the training must be completed at annual intervals.

Rationale and Summary

During a review of the home's investigation notes, the RPN's Surge Learning Education History report was reviewed which indicated the RPN did not complete the annual training in Extendicare specifically for, Extendicare Residents' Bill of Rights due date: February 28, 2024; Promote zero tolerance of abuse and Neglect of residents due dates: February 28, 2024 and Fire prevention and safety due date: January 31, 2024.

The Director of Care (DOC) confirmed during interview that the RPN did not complete the required annual training.

Failure to retrain direct care staff on an annual basis, resulted in staff potentially not being aware of new requirements and updates putting residents at risk of receiving improper care and services.

Sources: The home's education records, and an interview with the DOC.

[741746]

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Retrain all nursing, maintenance, housekeeping and dietary staff on the Birch resident home area on mandatory reporting of abuse specifically; The home's "decision tree" related to sexual abuse including the definition of sexual abuse.

2) Maintain records of the training provided including, but not limited to, training dates, times, attendees, trainer, and materials taught.

Grounds
The licensee failed to ensure that a resident was protected from sexual abuse by a co-resident.

Under FLTCA, 2021, the Ontario Regulation 246/22, section 3 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by anyone.

Rationale and Summary

The Director received a Critical Incident Report (CIR) for two separate incidents of alleged sexual abuse of a resident.

According to the CIR, a resident inappropriately touched another resident in a sexual manner on two separate occasions in the same day. A staff who witnessed the first incident confirmed that the interaction appeared to be unwanted by the victim.

During an interview with the DOC, it was confirmed sexual abuse was founded and the aggressor was placed on constant monitoring. The DOC also confirmed the police were notified.

In failing to ensure the victim was protected from sexual abuse, they became the recipient of sexual abuse.

Sources: CIR, staff and DOC interview,

[741746]
This order must be complied with by May 28, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Review sexual abuse definitions with Registered Nurse (RN) #105, RPN #103, PSW #101 and staff #100.

2. Review the home abuse policy with RN #105 and RPN #103 related to their roles for reporting abuse incidents in the home. Keep a documented record of the education provided.

3. Conduct audits of reported incidents of abuse for a period of one month, to ensure that the licensee's abuse policy is being complied with. Keep a documented record of the audit date, time, results of the audit and action taken.

Grounds
The licensee failed to immediately report two alleged incidents of resident to resident sexual abuse to the Director, and information upon which it was based.

For the purposes of the definition of “sexual abuse” in subsection any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;

Rationale and Summary

The Director received a CIR for two separate incidents of alleged sexual abuse of a resident.

According to the CIR, a resident inappropriately touched another resident in a sexual manner on two separate occasions in the same day. The aggressor was identified as the perpetrator in multiple incidents of sexual touching of co-residents during a period of three days following the reported incident.

Staff #100 who witnessed the first incident indicated during an interview that instead of intervening they called the RPN for assistance. Both residents were separated by the RPN with assistance from staff #100. The RPN again separated the residents on the second incident and moved the victim from the area.

The DOC indicated that the RPN and the RN on duty did not report the incident of alleged sexual abuse until one day after. The DOC indicated alleged sexual abuse of a resident should have been immediately reported by registered staff.

During an interview the RPN indicated they did not report the alleged sexual abuse because they did not know what to do. The RN indicated during an interview that the information provided by the RPN was not clear and they did not understand the severity of the incident.

One day later, a third incident occurred where the resident was observed touching another resident in a sexual manner. The incident was witnessed by a PSW who acknowledged during an interview that this interaction was unwanted by the victim. This incident was not reported in a separate CIR and was submitted late.

The DOC confirmed during the interview that management staff were unsure of how to report the incident.

Failure to immediately report alleged, suspected or witnessed sexual abuse placed the residents at further risk of harm.

Sources: CIR, interview with the DOC, staff #100, and the PSW.

[741746]

This order must be complied with by May 14, 2024

COMPLIANCE ORDER CO #003 Behaviours and altercations

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

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

1. Ensure that the resident's plan of care related to behavioural interventions, strategies and triggers specific to sexual behaviours is reviewed and updated once per week, at a minimum. The review must be completed by the home's behavioural support team, the nurse practitioner or physician, one registered nurse, one personal support worker and one compassionate care giver.

2. Communicate any changes made to the resident's plan of care related to behavioural strategies and interventions to the direct care staff at the beginning of each shift. Maintain a record of the communication, including the date and staff who were informed. Keep records available upon inspector's request.

3. Retrain all registered staff on Birch unit Homes "Behaviour Support Ontario (BSO) referral process". Provide names, dates and instructor. Keep records available upon inspector's request.

4. Conduct audits of the resident's 1:1 three times a week for one month for accuracy and completion of documentation. The audits shall be conducted by the BSO lead or a member of the management team. the BSO lead will keep a documented

record of the audit date, time, staff audited, results of the audit and any corrective action taken.

Grounds
The licensee has failed to ensure that procedures and interventions were implemented to assist residents on the Birch unit and to minimize the risk of altercations and harmful interactions between the residents.

Rationale and Summary

Resident #001 was admitted to the LTC in December, 2023, as per the residents' plan of care, the resident exhibited inappropriate sexual behaviours. A review of admission documents indicated the resident displayed physical aggression and public sexual behaviours.

Since admission to the home the resident displayed multiple occurrences of sexually inappropriate behaviours towards staff for seven days in which, no interventions were put in place. The BSO lead confirmed during the interview that they did not receive any formal referral only word of mouth.

Following a sexual abuse incident with resident #002, the resident was ordered an intervention by the physician to help prevent the resident from sexually abusing other residents. Following the initiation of this intervention, records indicated that this was not implemented on several occasions which lead to the resident sexually abusing residents #003 and #004.

A review of plans of care for the residents #002, #003, and #004 revealed no changes were made in their plans of care related to resident safety even though the home was aware that the strategies were not effective.

The DOC stated during the interview that the home should have updated interventions.

Ineffective behavioural management for resident #001 led to an increased risk of reoccurring incidents of physical harm towards residents on Birch unit.

Sources: CIR: 2851-000027-23, 2851-000001-24, Plans of care for residents #001, #002, #003, and #004, Interview with DOC, LTC home investigation package, Admission package for resident #001.

[741746]
This order must be complied with by May 28, 2024

COMPLIANCE ORDER CO #004 HOUSEKEEPING

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Environmental Services Manager (ESM) will re-train housekeeper #107 on contact disinfection and disinfectant contact times. Document what education was provided, the date of education provided, and the name of the person who provided the education. Make this information available to inspectors upon request.

2. Conduct one unannounced weekly contact disinfection audit for one month of housekeeper #107. The audits shall be conducted by the ESM or a member of the management team. the ESM will keep a documented record of the audit date, time, staff audited, results of the audit and action taken as necessary.

Grounds

The licensee has failed to ensure that contact surfaces were disinfected in accordance with manufacturer's specifications.

Rationale and Summary

In February, the LTC home went into a respiratory outbreak on a resident home area.

During observations of the home's cleaning and disinfecting practices, a housekeeper was observed wiping contact surfaces throughout multiple resident rooms. The inspector noted that after the housekeeper wiped the contact surfaces, that the surfaces did not remain wet. According to the housekeeper, the disinfectant used was the Accel Rescue Sporicidal Solution.

The manufacturing instructions of the disinfectant indicated the user was to apply the chemical to surfaces using a cloth or disposable wipe, and to ensure the surface remained wet for 10 minutes at 20 degrees Celsius. The Housekeeper informed the inspector that their normal practice was to apply the disinfectant on to a cloth and wipe the surface but did not usually ensure that the surface remained wet for 10 minutes.

The ESM confirmed that the housekeeper was required to ensure the contact surface remained wet for the duration of time specified in the manufacturer's instructions.

Failure to clean and disinfect high touch surfaces in a home area that was on outbreak placed the residents at risk of contracting infectious diseases.

Sources: Observations, Accel Rescue Sporicidal Solution manufacturing instructions, interviews with the housekeeper and the ESM.

This order must be complied with by May 14, 2024

[704757]

COMPLIANCE ORDER CO #005 INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 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)]:
1. The IPAC lead will provide face to face training for RPN #103 on the four moments of hand hygiene. The RPN will give a return demonstration to verify comprehension. Document what education was provided, the date of education provided, the name of the person who provided the education and any corrective action (s) provided. Make this information available to inspectors upon request.

2. Conduct one unannounced weekly hand hygiene audit for one month during RPN #103's medication pass. The audits shall be conducted by the IPAC lead or a member of the management team. the IPAC lead will keep a documented record of the audit date, time, staff audited, results of the audit and action taken.

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 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).

In February 2024, the LTC home went into a respiratory outbreak on a resident home area.

During observations of the outbreak resident home area, an RPN was observed preparing medications, entering resident rooms, and interacting with the residents. The RPN was seen touching door knobs and sets of keys before and after contact with residents without performing hand hygiene. The RPN acknowledged that hand hygiene should have been performed.

The homes policy titled Hand Hygiene indicated hand hygiene should be performed before and after contact with a resident. The IPAC lead also confirmed hand hygiene was required to be performed during any medication pass. The RPN's failure to perform hand hygiene in a resident home area in outbreak placed the residents at further risk when the RPN did not follow routine practices by not performing hand hygiene as required.

Sources: Medication pass observations, Hand Hygiene Policy #IC-02-01-08 Last updated January 2024, interviews with the RPN and the IPAC lead.

[704757]

This order must be complied with by May 14, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.