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: November 1, 2024	
Original Report Issue Date: October 11, 2024	
Inspection Number: 2024-1336-0003 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Cobourg, Cobourg	
Amended By The Inspector	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Non-Compliance #008, Written Notification: Food Production was amended to reword the finding.
Non-Compliance #012, Compliance Order #002: Communication and Response System was amended to correct condition 5), changing the reference to condition 3) to 4).
Non-Compliance #016, Compliance Order #006: Infection Prevention and Control was amended to clarify condition 11).

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3 - 6, 9 - 13, 16, and 17, 2024.

The following intake(s) were inspected:
Intake: #00112111 - Fall of a resident resulting in injury.
Intake: #00118104 - Follow-up #1 - Compliance Order #001, O. Reg. 246/22 - s. 102 (11) (b).
Intake: #00121449 - Complaint related to Infection Prevention and Control (IPAC) and housekeeping.
Intake: #00125102 - Complaint related to staffing and food quality.

The following intakes were completed in this inspection:
Intake: #00114077 - Fall of resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1336-0002 related to O. Reg. 246/22, s. 102 (11) (b) inspected by the Inspector.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff and others involved in the different aspects of care for a resident, collaborated with each other in the development and implementation of the place of care. Failing to ensure that the resident different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to a fall with injury.

A review of a resident records indicated the resident had sustained a number of falls.

During an interview with a Personal Support Worker (PSW), they indicated that a specified intervention to reduce the number of falls should be included in the resident's plan of care. A review of the care plan indicated that there was another specific intervention implemented instead. An interview with the Director of Care (DOC) Quality indicated that the resident's plan of care would need to be revised. At a later date, a review of the resident's care plan was revised to the specified intervention as indicated by the PSW.

A progress note documented by registered staff indicated a request for a specific activity to be implemented for the resident to reduce falls.

An interview with a Physiotherapy Assistant (PTA) confirmed that with the specified activities as requested, the resident would be less likely to fall. The Programs Manager indicated that they did not recall being informed of the requested activities. During the interview the Programs Manager indicated the expectation when a request is made for a resident to attend additional activities, they would inform the activation aide on the floor and a change in the resident's care plan would be made.

The licensee failed to consider and implement different approaches to care for falls prevention, placing the resident at an increased risk for falls.

Sources: CIR, resident's care plan and progress notes, interviews with PSW, PTA, Programs Manager and DOC Quality.

WRITTEN NOTIFICATION: POWERS OF RESIDENTS' COUNCIL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)

Powers of Residents' Council
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 to the Residents' Council in writing within 10 days of receiving advice by the Residents' Council of concerns or recommendations.

Rationale and Summary:

A complaint was received by the Director related to food quality.

The home had established a Residents' Council. A review of the August Residents' Council meeting minutes indicated that concerns and/or recommendations were advised by the Residents' Council.

There was no record of written responses relating to the above-mentioned advice.

The Programs Manager indicated that they were not aware of the requirement to provide a written response to the Residents' Council within 10 days of receiving the advice relating to any recommendations and that it would be completed going forward.

Failure to respond the Residents' Council in writing within 10 days of receiving advice on concerns or recommendations impact the evaluation of organized meal service and affects pleasurable dining experiences.

Sources: review of Residents' Council meeting minutes, interview with the Programs Manager.

WRITTEN NOTIFICATION: COMPLIANCE WITH MANUFACTERERS INSTRUCTIONS

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

The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary:

During a demonstration of the dilution concentration testing of the home's general disinfectant, the Environmental Services Manager (ESM) confirmed that they were the only person who did the testing.

The ESM provided a dated and initialed sign off record which included the procedure for dilution monitoring to be performed every time a new container of disinfectant was replaced and at least weekly, and there was no documentation of testing in the previous 12 weeks.

The ESM explained that the manufacturers' product representative gave no interval for the disinfectant concentration checks from the J-fill wall unit sharing that the home should follow their own policy. The ESM confirmed the home was to perform

the concentration testing at least weekly or every time the bottle was changed. By failing to ensure that staff used all equipment, such as the disinfectant concentration test strips in accordance with the manufacturers' instructions, the licensee placed residents at increased risk of acquiring healthcare-associated infections if there was delayed detection of a disinfectant dispenser dilution malfunction.

Sources: test strip sign off sheet for disinfectant dilution testing, test strip testing procedure, ESM interview.

WRITTEN NOTIFICATION: BATHING

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that each resident of the home was bathed, at minimum, twice a week by the method of their choice.

Rationale and Summary:

A complaint was received by the Director related to short staffing.

A review of bathing documentation in resident's care record for August and September showed the following:

- a number of residents' scheduled bathing activity did not occur
- a resident's scheduled bathing was not documented.

Interviews with PSW staff indicated that they were working short on the identified days that baths were missed. They indicated that they were not able to provide resident's their preferred method of bathing and received a bed bath instead. A PSW indicated that they were to make up the missed bath on the next shift. They all indicated that working short impacted their ability to provide bathing care.

Failure to ensure that the residents received their baths by the method of their choice affects personal hygiene and quality of life.

Sources: resident care record, interviews with PSWs and the DOC.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that a resident fall prevention interventions were implemented as part of the licensee's fall prevention and management program.

Rationale and Summary:

A CIR was submitted to the Director related to a fall with injury.

A review of a resident records indicated the resident had sustained a number of falls. The resident's care plan specified that a specific falls prevention intervention was to be implemented. Documentation completed by registered staff after a fall for the resident, indicated that the specified falls prevention intervention was not provided. A review of documentation for that same day that the resident fell indicated that staff had not implemented the falls prevention intervention.

The resident sustained a fall on another date, and documentation completed by registered staff specified that the resident was required to have a specific falls prevention intervention in place prior to the fall, however it was not provided to the resident. An interview with a PSW, confirmed that the falls prevention intervention was not in place prior to the resident sustaining the fall.

The DOC Quality acknowledged that the expectation was that falls prevention interventions was be implemented for the resident as part of their plan of care.

When registered staff failed to implement the resident's falls prevention plan of care, it impacted falls prevention measures for the resident.

Sources: CIR, resident's care plan, documentation, interviews with a PSW and DOC Quality.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

Accordance to subsection (2.1) the following are authorized persons for the purposes of subsection (2): If the skin assessment does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, either of the following: i. A member of a regulated health profession acting within their scope of practice.

Rationale and Summary:

A resident's clinical record was reviewed to determine if the home's infection surveillance practices were in compliance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard).

An electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) for a resident showed orders for a treatment to be implemented twice daily.

Initials were missing on the eTAR for a number of dates. There was a period in which weekly skin assessments lacked any reference to monitoring the affected area undergoing the treatment.

Documentation indicated an entry from the NP after the initiation of the treatment noting an observation to the affected area; the treatment is being implemented and to continue the treatment plan. Weeks after the initial treatment plan the NP documented another observation. A review of the documentation indicated no weekly monitoring set up for the resident. A number of weeks elapsed between the NPs skin assessments of the affected area, with no documentation of skin assessments by the registered staff.

The Registered Practical Nurse (RPN) Wound Care Champion confirmed that when staff were administering treatments for impaired skin, they would need to make sure there was a care plan focus for that and a weekly assessment. A weekly impaired skin integrity assessment was to be done for residents if there was skin redness, lesions, lacerations, skin tears and if a treatment cream was initiated. The RPN indicated that staff should have known to put a weekly skin assessment in place for the resident when the treatment was ordered .

RPN confirmed providing a treatment to the resident affected skin area, described the affected area and indicated it didn't look infected. They explained that sometimes there is a push assessment when a resident's skin is a different colour, but they didn't recall a weekly skin assessment for the resident.

The NP indicated they assumed that the resident's affected area had improved until it was brought to their attention. The NP's progress note indicated an observation and change of the affected area. They explained that they attempted to relieve pressure from the affected area.

By failing to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly by an authorized person, the licensee placed the resident at increased risk of medical complications related to delays in treatment of a worsening skin condition.

Sources: resident clinical records, interviews (RPN, Wound Care Champion, NP).

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that residents who required continence care products received sufficient changes to remain clean, dry, and comfortable.

Rationale and Summary:

A complaint was received by the Director related to short staffing.

A review of the plan of care for a number of residents indicated that they were incontinent of urine and bowel and that they required the use of briefs. A review of continence care documentation in the residents' care record indicated that the residents continence care was not documented.

Interview with a PSW indicated that they were working short on a specific date. They indicated that they were involved in the residents' personal care on that date but were not able to provide all residents' continence care needs including changing of briefs. They indicated that working short impacted their ability to provide continence care.

Failure to ensure that the residents received their continence care impacted the residents ability to remain clean, dry, and comfortable.

Sources: residents care record and written plan of care, interviews with a PSW, the Administrator and the DOC.

(A1)
The following non-compliance(s) has been amended: NC #008

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that all food in the food production system were served using methods to preserve taste, appearance and food quality and prevent food borne illness.
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure

there is a food production system in place so that that all foods in the food production system are served using methods to preserve taste and food quality, and prevent food borne illness, and that it is complied with.

Specifically, staff did not comply with the licensee's policy End Point Food Temperatures, which stated that Cooks were to take end point cooking temperatures and to record temperatures on the applicable document.

Rationale and Summary:

A complaint was received by the Director related to food quality.

A review of the kitchen production report indicated that the end point cooking temperatures for a number of dates, were not all documented. Interview with the Food Services Manager indicated that the expectation of the cooks was to document all end point cooking temperatures taken at the final stage of cooking.

Failure to document end point food temperatures impacts assurance that foods were served at a proper temperature, using methods to prevent food borne illness.

Sources: kitchen production report, the licensee's policy End Point Food Temperatures, and an interview with Food Services Manager.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to ensure that foods were served at temperatures that were both safe and palatable for residents.

Rationale and Summary:

A complaint was received by the Director related to food quality.

Records for point of service food temperatures specific home areas were reviewed and missing temperature records were identified on eight specific dates.

The Food Services Manager indicated that the dietary aides were responsible to record the point of service food temperatures.

Failure to ensure foods were served at a safe temperature poses risk of harm to residents and affects a pleasurable experience for residents.

Sources: point of service food temperature sheets; and interviews with Food Services Manager.

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #010 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 failed to ensure that hazardous substances at the home were kept inaccessible to residents at all times.

Rationale and Summary:

A resident was observed talking in confused sentences and wandering in close proximity to an unattended housekeeping cart. The upper compartment of the cart was observed to be open and a spray bottle was observed on top in clear view. The cart was unlocked when the housekeeper was observed to be accessing it for cleaning products and changing out soiled cloths and mop heads.

The housekeeper confirmed that their housekeeping cart was not locked when they were around the cart during the day, even though they had keys for it. When asked if it was possible that a resident could get into their cart when they were in a resident bathroom, they confirmed that everything was possible . The housekeeper indicated that the spray bottle on top of the cart contained window cleaner.

By failing to ensure that hazardous substances at the home were kept inaccessible to residents at all times, the licensee placed residents at risk of potential harm from exposure to unlocked accessible cleaning chemicals.

Sources: observation on the secure Birch unit, interview with a Housekeeper.

COMPLIANCE ORDER CO #001 CMOH and MOH

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

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

1) The home's Corporate/Management team in consultation with the Environmental Services Manager (ESM) will revise the staffing plan for the environmental services department, to ensure there is adequate staffing to complete at a minimum twice daily cleaning of all high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas during outbreaks.

2) The ESM and IPAC Lead will collaborate, develop and provide in-person training to all environmental services staff that includes, at a minimum: the requirement of twice daily cleaning of all high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas during outbreaks and the procedures related to that requirement such as: cleaning times, surfaces to be cleaned, documentation of cleaning, disinfectant product name and contact time, breaking the chain of transmission at resident doorways, etc.

3) Keep a documented record of the training in condition 2) including: date, content, trainer name (ESM or IPAC Lead) and signature, list of environmental services (ES) staff requiring the training, ES staff signatures attesting that they have received and understood the training and provide this record to Inspectors immediately upon request.

4) In the event that an outbreak is declared in the home between the serving date of the licensee report and the time of the next follow up inspection, the IPAC Lead or in their absence one of the home's management team, will complete audits three times a week on all three resident units, to determine compliance with twice daily cleaning of all high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas during outbreaks.

5) Keep a documented record of all completed audits as per condition 4) , including at minimum: the date and resident unit, whether or not compliance was observed, actions taken for non-compliance if identified, auditor's name and signature, and make the record immediately available to Inspectors, upon request.

Grounds:

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home. Specifically, the Ontario Ministry of Health 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024, s. 3.12 - Enhanced Environmental Cleaning and Disinfection, which states that a minimum twice daily for high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons,

etc.), treatment areas, dining areas and lounge areas are to be cleaned during an outbreak.

Rationale and Summary:

A CIR was submitted notifying the Director that a COVID-19 outbreak was declared on the a specific unit of the home. Five days later an update was submitted reporting that the outbreak had spread to two out of three units in the home, with new cases identified on a specific unit, and Public Health had declared it to be a facility-wide outbreak.

The Outbreak Management Team Daily Meeting Minutes form under the subsection of 'Priority Items', had a box checked 'yes' for extra environmental cleaning implemented right away, and in hand writing next to that in brackets was a note indicating there was no Housekeeper for a specific unit that day, *scheduled 1 – 9 pm. No documentation related to the lack of housekeeping was entered in the comments/discussion section of the meeting minutes form to explain any actions that were taken by the charge nurse or any of the other three management representatives who signed for their attendance at the meeting that day.

The Housekeeper common areas cleaning sign off sheet provided by the ESM showed that twice daily high touch cleans were missed during the home's COVID-19 outbreak. Two days in the week leading up to the outbreak noted no cleaning coverage, short staffed, for two units. After the outbreak was declared 2024, there were four days with no record of any cleaning signed off for two units. No deep cleaning sign off sheet for common areas was provided for a specific unit. At the bottom of the sheet, a hand written message in black marker stated the following message: *During Outbreaks high touch cleans must be completed two times a day.*

The ESM confirmed that high touch surfaces were cleaned twice daily during an outbreak only if staff had time, confirming that there was not always the time to do a second clean as the workers had a standard list to do in eight hours and they likely performed one cleaning a day because of time constraints. They explained that they were not able to get extra Housekeepers to help with the extra cleaning because agency workers would need to complete online training before working and because they could be getting someone different each time it wasn't possible to train them all.

By failing to provide at a minimum twice daily for high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas are to be cleaned during an outbreak, as per recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act, the licensee placed residents at increased risk of illness and medical complications from contact exposure with infectious pathogens during a COVID-19 outbreak.

Sources: CIR, Outbreak Management Team Daily Meeting Minutes form, Housekeeper Common Areas Cleaning sign off sheet, ESM interview.

This order must be complied with by December 16, 2024

(A1)
The following non-compliance(s) has been amended: NC #012

COMPLIANCE ORDER CO #002 COMMUNICATION AND RESPONSE SYSTEM

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

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

1) The DOC or nursing designate will update resident #006 and #007's care plan/Kardex to include what the residents preferences are for call bell location while they are sitting in a wheelchair in their room, involving the substitute decision maker in the plan as needed.

2) A member of the nursing management team will conduct daily audits for a period of two weeks, at varied times of the day, to ensure that residents #006 and #007 have their call bells easily visible and within reach while sitting in a chair/wheelchair in their rooms.

3) Keep a documented record of the completed audits including the nursing management staff name who completed the audit, the location of the call bell, whether or not compliance was observed, and any actions taken for non-compliance if identified, and make the record immediately available to Inspectors, upon request.

4) Nursing Management staff will coordinate and provide education for front-line Poplar Unit nursing staff; RN, RPN, PSW including agency staff, to reinforce their understanding of the requirement for residents to have the resident-staff

communication and response system (call bell) in a location that can be easily seen, accessed and used by residents, staff and visitors at all times, regardless of the residents cognitive abilities.
5) Keep a record of the names of the Poplar Unit front-line nursing staff who meet the criteria for receiving the education in condition 4), education content, how and when the education was provided, the signature of the staff member who received the education and make available to inspectors immediately upon request.

Grounds:

The licensee failed to ensure that the resident-staff communication and response system (call bell) could be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary:

During a tour of the home the inspector observed that two residents, did not have their call bells within reach while in their rooms.

A resident was observed sitting facing the window in their room and the call bell was not within reach, it was laying behind them on their bed.

A resident was unsuccessful in their attempt to reach their call bell which was closed inside the top drawer of their bedside table.

Care plan reviews for both residents revealed that they required staff assistance for care needs.

A resident confirmed using the call bell to call for help and had asked staff to leave

it in the top drawer of their bedside table. They acknowledged requiring assistance from staff and during their unsuccessful attempt to reach the call bell, they acknowledged it was hard to reach.

A PSW explained that the reason why the call bell was left on the resident bed was that they were not capable of using it, and added that it would be a trip hazard if it was moved across the room to the window area where the resident was sitting.

RPN confirmed that they know it is always good to have call bells in place, but the resident wouldn't know how to press it. When asked about the home's policy they confirmed that staff should always try to have a call bell close in place.

By failing to ensure that the resident-staff communication and response system (call bell) could be easily seen, assessed and used by residents, staff and visitors at all times, the licensee placed residents at risk of potential harm from delayed response to care needs.

Sources: call bell placement observations, residents and clinical records, interviews (a resident, PSW, RPN).

This order must be complied with by December 16, 2024

COMPLIANCE ORDER CO #003 NURSING AND PERSONAL SUPPORT SERVICES

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) The Director of Nursing will develop a written process that includes the following:

a) Assign a Registered Nurse who regularly works in the home or a nursing manager on every shift that will be responsible for determining the residents' safety and care needs are met when there are staffing shortages.

b) Provide direction to the assigned Registered Nurse or nursing manager to obtain a verbal report from nursing staff on each resident home area regarding workload issues at the beginning and middle of each shift when there are staffing shortages.

c) Provide direction to the assigned Registered Nurse or nursing manager on determining when to reassign staff to a different resident home area throughout the shift, to meet the residents' assessed care needs. Staff are to collaborate and work together until all residents receive personal care in a timely manner.

d) Document a brief description of the number of nursing staff that was present on shift when staffing shortages occurred, the actions implemented on each shift, and when resident care needs have not been met.

2) Provide the written process and the documentation to Inspectors immediately upon request.

Grounds:

The licensee has failed to ensure that the staffing plan provided for a staffing mix was consistent with the residents assessed care when the residents did not receive care according to their assessed needs.

Rationale and Summary:

A complaint was received by the Director related to short staffing.

Registered nursing staff, PSWs and residents reported delays in personal care due to working short. Registered nursing staff and PSWs indicated that bathing care was frequently impacted when short staffed.

Non-compliance was identified within this report regarding staffing shortages:

-O. Reg. 246/22, s. 37 (1) regarding bathing not provided by their method of choice for multiple residents,

-O. Reg. 246/22, s. 56 (2) (g) regarding continence care needs were not met for multiple residents

The DOC indicated that the staffing schedule changed daily and at times within the last month that staffing levels were below the staffing complement. The DOC indicated that there was a part time registered practical nurse vacancy and a full time temporary personal support worker vacancy not filled according to the staffing plan. The DOC indicated that in the past month agency personal support worker staffing had been used to work in the home at night.

The Administrator indicated that the staffing plan was evaluated on a yearly basis and that appropriate staffing mix for the number of residents, staffing vacancies, and

recruitment commitments was reviewed. They indicated that review of unmet care needs was not necessarily part of the annual staffing plan evaluation and that they could include this review moving forward.

Failure to ensure that the staffing plan provided for a staffing mix that was consistent with the residents assessed care impacted the provision of personal care for residents.

Sources: staffing schedule, Staffing Contingency Plan reviewed January 25, 2024, and interviews with the DOC, the Administrator, and other staff.

This order must be complied with by December 16, 2024

COMPLIANCE ORDER CO #004 HOUSEKEEPING

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)
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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

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

Specifically, the licensee shall:

1) The home's Corporate/Management team in consultation with the ESM will revise the Environmental Services Department staffing plan, to ensure adequate staffing is available to complete, at a minimum, the daily cleaning requirements of the home.

2) The ESM will submit a weekly status report for four weeks to the home's Management Team, sharing the status of the effectiveness of the changes made to the environmental services staffing plan in maintaining the home's daily required cleaning for all three resident home areas. The report will include actions taken if the home's cleaning requirements were not met and corrective actions that were taken to prevent recurrence, and immediately provide this status report for review by Inspectors, upon request.

3) The ESM in collaboration with the IPAC Lead will provide in-person training to all environmental services staff that includes, at a minimum: the procedures for daily cleaning of the home, expectations for daily resident room cleaning and other shared spaces in the home, as per the cleaning frequencies determined by the home, using a risk stratification approach.

4) Keep a documented record of the training in condition 3) including: date, content, trainer name (ESM or IPAC Lead) and signature, list of environmental services (ES) staff requiring the training, ES staff signatures attesting that they have received and understood the training and provide this record to Inspectors immediately upon request.

Grounds:

The licensee has failed to organize a program of housekeeping under clause 19 (1)

(a) of the Act, to ensure that procedures were developed and implemented for cleaning of the home.

Rationale and Summary:

A complaint was received by the Director describing concerns related to the home's alleged inadequate housekeeping services.

During the inspector's initial tour, a Housekeeper was seen consecutively entering three different resident rooms and a shared hallway bathroom, changing out their gloves and removing a bag of garbage from each room, and no cleaning was observed.

July 1 to August 10, 2024, the Housekeeping Assignments record showed a line through the dates of July 9 to 13 and was completely missing July 14, 2024. The word 'away' was handwritten under the line with arrows on each side, and no Housekeeper initials were entered to signify that the cleaning had been done. Altogether, there were 13 days that were missing Housekeeper initials, including a pattern of five out of six Fridays.

The ESM confirmed in an email that the home had one Housekeeper to cover the entire long term care home (LTCH) from July 9 to 12, 2024 so they performed high touch cleaning and garbage only. On July 13, 2024, there was no Housekeeper for a specific unit, and July 14, 2024, there were no Housekeepers available for cleaning of the entire LTCH.

A Housekeeper confirmed during the initial tour, that they were not doing any cleaning just going in to remove the garbage. They confirmed that the Housekeeper assigned to a specific unit wasn't working that day so they had been asked by the

ESM to cover that area after they were done their work on the attached retirement home side. They confirmed that they were just removing garbage and they were not cleaning anything in the resident's room.
The ESM explained that a Housekeeper had called in to cancel their shift for a specific unit so they had reached out to their casual employees who were also unavailable, so they delegated the work to an employee that was already working on the retirement home area, acknowledging it was not a traditional cleaning day but that would limp them on until tomorrow. When informed that the Housekeeper was only changing garbage and not performing any cleaning in the resident rooms on a specific unit, they confirmed that they were going to remind the Housekeeper that high touch cleaning was also required.

By failing to organize a program of housekeeping under clause 19 (1) (a) of the Act, to ensure that procedures were developed and implemented for cleaning of the home, the licensee placed residents at increased risk of disease transmission and illness from exposure to contaminated environmental surfaces.

Sources: A Housekeeper observation, July/August Housekeeping Assignments sign off record, ESM email, staff interviews.

This order must be complied with by December 16, 2024

COMPLIANCE ORDER CO #005 DESIGNATED LEAD - HOUSEKEEPING, LAUNDRY,MAINTENANCE

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 98 (2) (a)
Designated lead — housekeeping, laundry, maintenance
s. 98 (2) The licensee shall ensure that the designated lead has the skills, knowledge

and experience to perform the role, including,
(a) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) The Administrator or a Corporate Designate will educate the ESM on their role and responsibilities in the home.

2) The Administrator or a Corporate Designate will educate the ESM on the legislation specific to housekeeping, laundry services and maintenance services programs.

3) Keep records of the education as required under conditions 1) and 2), including content, how it was provided and by whom, dates when completed, and signatures of completion by the educator and the ESM.

4) The ESM must successfully complete all six of the online 'Infection Prevention and Control for Environmental Cleaning in Health Care Online Learning Modules' provided by Public Health Ontario. https://www.publichealthontario.ca/en/Health-Topics/Infection-Prevention-Control/Environmental-Cleaning/EC-Settings.

5) Keep the certificates of completion for the six online modules, as ordered in section 3 above. Make these available to the inspector immediately upon request.

6) The ESM will be provided with work time to review the Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee (PIDAC), 'Best practices for environmental cleaning for

prevention and control of infections in all health care settings.' 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2018. After completion of the review, sign that it has been done and keep a record of the review date.
7) The ESM is to review the home's outbreak plan and any related policies with the IPAC Lead, and collaborate in the revision of the plan, using the home's risk stratification matrix, to update and detail outbreak cleaning frequencies for all areas of the home. Keep a signed and dated record of the completed review of the revised plan.

8) Provide records of above immediately to inspectors upon request.

Grounds:

The licensee failed to ensure that the ESM had the skills, knowledge, and experience to perform the role, including, knowledge of evidence-based practices and, if there were none, prevailing practices relating to housekeeping.

Rationale and Summary:

The ESM demonstrated a lack of skill and knowledge of best practices in cleaning when they confirmed that their education and training was not related to their current job.

A Housekeeper was observed going from resident room to resident room on a specific unit removing garbage, missing hand hygiene when changing their gloves, not performing resident room cleaning, and when asked about their assignment they confirmed that they were not doing any cleaning, they had been instructed by the ESM to empty garbage only.

Lack of skill was demonstrated when disinfectant concentration testing was to be conducted by the ESM at least weekly or when the disinfectant bottle was changed, and it had not been tested since June 18, 2024. The ESM confirmed that this was not following policy and they had not set up a method of notification when the bottle was changed by housekeeping staff.

During the July 9 to 14, 2024 housekeeping shortage, the ESM failed to fill cleaning assignments and left resident areas of the home without the required housekeeping services for multiple days.

The ESM acknowledged awareness of the need for twice daily resident room cleaning for those on additional precautions during outbreaks, however the extra work would not likely be done due to time constraints in the Housekeepers eight-hour shift. The ESM acknowledged they do the best they can when staff call in, but acknowledged that there wasn't always time for a full room clean, just garbage and high touch cleaning.

The ESM confirmed they were unfamiliar with the home's cleaning policy that included risk stratification for cleaning frequencies. The policy outlined that the ESM was to develop job routines and cleaning schedules and calendars to meet the cleaning needs of the home using these appendix's, and to monitor and revise as required based on available resources.

The ESM did not recall the evidence-based policy related to standard cleaning, and emailed their District Manager for a copy of the policy which provided detailed information for the housekeeping department related to best practices in cleaning.

By failing to ensure that the ESM had the skills, knowledge, and experience to perform the role, including, knowledge of evidence-based practices and, if there

were none, prevailing practices relating to housekeeping, the licensee placed all LTCH residents at risk of illness related to contact transmission of healthcare-associated infections (HAIs).
Sources: observations of cleaning practices, standard cleaning policy and cleaning frequency policy, and staff interviews (a Housekeeper and the ESM).

This order must be complied with by December 16, 2024

(A1)
The following non-compliance(s) has been amended: NC #016

COMPLIANCE ORDER CO #006 INFECTION PREVENTION AND CONTROL PROGRAM

NC #016 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)]:
Specifically, the licensee shall:

1) The IPAC Lead will provide in-person training to Housekeeper #106 about the four moments of hand hygiene, including a demonstration by the Housekeeper of hand hygiene during the steps of putting on and taking off personal protective equipment. Keep a record of the training including the trainer's signature (IPAC Lead), training

content, date completed, and the Housekeeper's signature attesting to the training and understanding of the content.

2) The IPAC Lead will complete hand hygiene audits twice weekly for four weeks, ensuring at least two audits are completed on two separate dates for each of the housekeeping staff in the Environmental Services Department. Weekly communication will be shared with the ESM providing results of the hand hygiene audits and any corrective actions taken. Keep a record of the date of each audit, which of the four moments were observed, whether or not the Housekeeper was compliant, any actions that were taken if non-compliance was identified, including a signature of the auditor (IPAC Lead) and the Housekeeper who was audited.

3) Provide a summary and analysis of the hand hygiene audit results to the Licensee, Administrator and ESM at the end of the four weeks and include the summary on the agenda for the next quarterly IPAC meeting.

4) Provide training to Housekeepers #106 and #116, RPN #108 and #111 regarding PPE stewardship including at minimum: the indications for glove use, proper glove storage, and putting on and taking off of gloves in conjunction with the four moments of hand hygiene.

5) The IPAC Lead will complete at least two PPE audits, for each of the following staff: Housekeepers #106 and #116, RPN #108 and #111 over a four week period. Keep a record of the date and location (resident unit) of each audit, whether or not the Housekeepers or RPNs were compliant with PPE stewardship practices including appropriate use and storage of gloves, any actions that were taken if non-compliance was identified, and include a signature of the auditor (IPAC Lead) and the staff for each audit. Keep a record of the audits, include time to discuss the PPE audit results on the agenda for the next quarterly IPAC meeting and make the

records available to Inspectors immediately upon request.
6) The IPAC Lead will collaborate with Corporate Extendicare staff to complete a review and revision of the home's 'Mechanical Lifts Procedure' dated Nov 2023, to provide information regarding acceptable storage location of dedicated resident 'sit to stand' slings, and detailed cleaning/disinfection steps for the shared resident care lift equipment, referencing the manufacturer's recommendations for cleaning.

7) A copy of the newly revised 'Mechanical Lifts Procedure' will be distributed to front line staff who are responsible for the use and care of 'sit to stand' slings/lifts for resident care. A sign off record will be kept which includes the required staff names, with a date and signature line for attesting that they have read and understood the updated procedure.

8) The IPAC Lead will conduct a weekly audit for four weeks, recording compliance observations for all home areas where the 'sit to stand' lift is in use, recording if there was compliance with the revised 'Mechanical Lifts Procedure' or non-compliance and any corrective actions that were taken. Keep a dated and signed record of the audits and make available immediately to Inspectors upon request.

9) The home's outbreak management plan will be updated to include protocols to follow Additional Requirement 4.3 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023. Specifically, the licensee shall ensure that following the resolution of an outbreak, the outbreak management team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

10) The ESM will review the home's policy, 'Cleaning Frequency' last updated Oct 2023 and use Appendix 1 - Recommended Cleaning Frequencies and Appendix 2 - Risk Stratification Matrix (Cleaning Frequencies), to update and revise the environmental services job routines, cleaning schedules and calendars to meet the cleaning needs of the home. Keep a signed and dated record of when the policy and appendices were reviewed by the ESM and provide a copy of the updated/revised job routines, cleaning schedules and calendars for the Environmental Services Department and make available immediately to Inspectors upon request.

11) The IPAC Lead will collaborate with department managers to review all job roles in the home and develop a list of the IPAC skills that are required for each role. The IPAC Lead will develop and implement a schedule for auditing the required IPAC skills for all staff in each job role, at least quarterly.

Grounds:

1. The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented, in accordance with section 9.1 (b) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023. Specifically, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: 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).

Rationale and Summary:

During the initial tour of a specific unit, a Housekeeper was observed entering three different resident rooms and a shared bathroom, removing a bag of garbage and changing to a new set of gloves for each room, and performing no hand hygiene until they were approached by the inspector for an interview.

The Housekeeper confirmed they were only changing gloves between resident rooms because they were just collecting garbage and not doing any cleaning, so would only be cleaning their hands about every third or fourth room.

The IPAC Lead confirmed that when a staff member moves from one resident room to another, that would be one of the required four moments for hand hygiene.

By failing to ensure at minimum Routine Practices shall include: hand hygiene, including, but not limited to, at the four moments of hand hygiene , the licensee placed all LTCH residents at risk of illness related to contact transmission of healthcare-associated infections (HAIs).

Sources: observations of Housekeeper, interviews (a Housekeeper and IPAC Lead).

2. The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk, including having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions, in accordance with Additional Requirement 6.1 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

The definition of PPE stewardship includes all aspects of managing PPE in the home

such as: ensuring adequate supply, making choices about distribution, and ensuring that PPE is selected, used and disposed of properly. It should also include ensuring that PPE is selected and used in an evidence-based manner.

Rationale and Summary:

During the course of the inspection, several examples of concerns with PPE stewardship and incorrect glove use were identified. A Housekeeper was observed repeatedly contaminating the glove box with uncleaned hands when they were changing out their gloves after garbage removal, between several resident rooms on a specific unit, during the initial tour of the home. There were multiple observations of the Housekeeper touching surfaces on the housekeeping supply cart in the hallway with gloves that had been contaminated during a resident room clean on a specific unit. The clean glove box was also contaminated with uncleaned hands when they changed out their gloves after the resident room and bathroom clean.

A RPN accompanied the inspector for a walk around the a specific unit and found the PPE cart for a resident's room, who required precautions, was stocked with one glove size, and the RPN pointed to the one glove holder on the wall for each hallway, which was not always close to the isolation rooms. There were no gloves on either PPE cart for two resident rooms that were on precautions.

The RPN explained that gloves were stored on top of the isolation carts outside the resident's room, unfortunately they were supposed to be there (outside of a specific room) and they were not. They explained that the medication cart might not have the correct size for them, so they would take a supply and have them ready in their pockets to use for application of creams to multiple residents. They confirmed it was a bad habit to put the gloves in their pockets, because their pockets could be

dirty, and they were going to try and break that habit and discourage the staff they work with from doing so as well.

A Housekeeper explained that they were taught to change their gloves every so often, like when they go in and out of the room and when changing mops.

The IPAC Lead confirmed in an interview that they would not promote the practice of putting extra gloves in uniform pockets, it would be preferable to pull from access points. The PPE carts should have everything that is needed, but if it didn't, they could put a box that fits on the cart or take from the wall access point.

The RPN described that they usually access gloves on the walls in the hallway. They described putting an extra pair of gloves in their pocket, because they wear a lot of gloves. They explained that sometimes they go into the resident's rooms with gloves on because they would be touching their personal items like mugs and doors, and honestly it was just a preference to wear gloves. They confirmed if isolation rooms were not near a glove holder it would be important to have the gloves at the doorway and technically there should be gloves on the PPE carts.

By failing to make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk, including having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions, the licensee placed all residents at increased risk of illness from contact transmission of infectious organisms.

Sources: observations, PIDAC best practice document 'Routine Practices and Additional Precautions in All Health Care Settings, November 2012, staff interviews (Housekeepers, RPN's and IPAC Lead).

3. The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed at minimum to ensure Routine Practices included use of environmental controls, such as location/placement of residents' equipment and cleaning, in accordance with Additional Requirement 9.1 (e) i. under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

Rationale and Summary:

During the initial tour of the home several ‘sit to stand’ lifts located in clean equipment areas located in between units, were observed with a sling draped over the top of the lift. This observation was evident on a number of days and units over the course of the inspection. Interviews confirmed that the IPAC Lead and front-line resident care staff had a different understanding of the required cleaning/disinfection of the slings for the ‘sit to stand’ lift.

Two staff were observed using the 'sit to stand' lift, in the hallway of a specific unit. The lift was then wiped down by one of the staff with a disposable disinfectant wipe and the used sling was draped over the top of the equipment.

Disinfecting protocols were unclear after review of the home’s procedure, which indicated, to complete wipe down of Mechanical Lift using appropriate cleansing agents according to set schedule.

When a PSW was asked about a sling draped over the top of a 'sit to stand' lift in the clean equipment cubicle area located in the hallway of a specific unit, they acknowledged that sometimes when it's out there it gets used on multiple people. They acknowledged that it does happen that it gets shared between residents. They

described cleaning the high touch areas of the lift with disinfectant wipes, but noted that the wipes could not be used on the slings, so when they were soiled, they were sent to laundry.

The IPAC Lead explained that the home's practice was to wipe down the sling and the lift with disinfectant wipes after each resident use.

A RPN confirmed that they regularly helped out with the 'sit to stand' lift, and sometimes when unhooking, the sling would get tossed on top, and that shouldn't be done because every resident should have their own sling. They explained that a dedicated sling should be in the resident's room, and you wouldn't know if a sling was clean or not if it was draped over the top of a lift.

By failing at minimum to ensure Routine Practices included use of environmental controls, such as location/placement of residents' equipment and cleaning, the licensee placed residents at increased risk of healthcare- associated infections from contact with contaminated resident care equipment.

Sources: observations, procedure, staff interviews (a PSW, RPN and IPAC Lead).

4. The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented, in accordance with Additional Requirement 4.3 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023. Specifically, the licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary:

A compliant was received by the Director related to multiple concerns with IPAC practices of the home. IPAC Checklist questions were used to assess the home's compliance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

The OMT final meeting minutes were reviewed and did not include an analysis of the effectiveness of IPAC practices in the management of the outbreak or any recommendations to the licensee for improvements to outbreak management practices.

A copy of the email sent to the Extendicare Regional Director reported outbreak statistics only, and did not contain a summary of findings related to the assessment and recommendations of the effectiveness of the IPAC practices in the management of the outbreak.

The IPAC Lead confirmed that there was no summary of findings shared with the licensee regarding recommendations for improvements to outbreak management practices, because they do not have a form for that.

By failing to conduct a debrief session with the OMT to assess the effectiveness of IPAC practices in the management of the outbreak and provide a summary of findings making recommendations to the licensee for improvements to outbreak management practices, the licensee placed residents at increased risk of infectious disease exposure from potentially ineffective outbreak management practices during future outbreaks.

Sources: OMT final meeting minutes, IPAC Lead email to Regional Director, IPAC Lead interview.

5. The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented, in accordance with Additional Requirement 5.6 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023. Specifically, the licensee failed to ensure that there were policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the surfaces were cleaned at the required frequency.

Rationale and Summary:

A compliant was received by the Director related to multiple concerns with IPAC practices of the home. IPAC Checklist questions were used to assess the home's compliance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

During the initial tour of a specific unit, a Housekeeper was observed entering three different resident rooms and a hallway bathroom, putting on a new set of gloves for each room, removing a bag of garbage, and not performing any room cleaning or hand hygiene.

The home's policy, directed the ESM to identify specific areas of concern. This policy was to be used when developing job routines, cleaning schedules and calendars to meet the cleaning needs of the home.

A Housekeeper indicated a specific unit had no Housekeeper that day and they had been asked to cover it at the end of their regular shift. They confirmed that they

were just removing garbage and not cleaning anything in the resident's rooms. The Housekeeper indicated if they were filling in for a missing Housekeeper they would go to that unit at the end of the day, and if they saw something visibly soiled like a dirty toilet, they would clean it, but otherwise just pick up the garbage. When filling in you don't do much, but picking up their garbage is an issue for people.

The ESM acknowledged that there had been times when there was nobody to do the cleaning so the ESM or their assistant would jump in and assist, but the room would not get a full clean because they'd be working two jobs. The ESM confirmed that they had not scored the different areas of the home according to the Risk Stratification Matrix and had never seen the home's Extendicare Appendix 2 Risk Stratification document.

By failing to ensure that there were policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the surfaces were cleaned at the required frequency, the licensee placed residents at increased risk of healthcare-associated infections from contact with contaminated surfaces.

Sources: Housekeeper observation, policies, staff interviews (Housekeepers and ESM).

6. The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented, in accordance with Additional Requirement 7.3 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023. Specifically, the licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and b) Ensures that audits are performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills

required of their role.

Rationale and Summary:

A compliant was received by the Director related to multiple concerns with infection prevention and control (IPAC) practices of the home. IPAC Checklist questions were used to assess the home's compliance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

During the initial tour of a specific unit, a Housekeeper was observed entering three different resident rooms and a hallway bathroom, putting on a new set of gloves for each room, removing a bag of garbage, and not performing any room cleaning or hand hygiene.

The Housekeeper was observed contaminating the housekeeping cart surfaces with contaminated gloves three times during a resident room clean, once to dispose of the soiled microfibre cloth and obtain the toilet chemical, second to dispose of a soiled toilet brush and get a new replacement one, and the third time to place the toilet chemical back into the cart. Gloves were changed without hand hygiene when the Housekeeper began preparing their mop to clean the resident room floor.

There was no documentation provided by the home to show that the IPAC Lead was performing audits of the required IPAC skills for each job role, in all the departments quarterly.

The Housekeeper explained that they were taught to change gloves every so often, like every time they go in and out of the room and when changing mops and so on. Taught to do hand hygiene every time they came out of the room and before going

to the next room.

The IPAC Lead explained that they were primarily responsible for conducting audits for the nursing/personal support workers and the other departments such as Environmental, Recreation, and Dietary did their own auditing. They could not confirm that they had performed an analysis of each job role to determine what IPAC skills were required.

By failing to ensure that audits were performed by the IPAC Lead regularly (at least quarterly) to ensure that all staff could perform the IPAC skills required of their role, the licensee placed residents at increased risk of healthcare-associated infections due to a potential delay in correcting inaccurate IPAC skills by staff in the home.

Sources: Housekeeper observations, staff interviews (Housekeeper, IPAC Lead).

This order must be complied with by December 16, 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 #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, 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:

Non-compliance history for O. Reg. 246/22, s. 102 (2) (b):
Inspection #2024-1336-0002 - Written Notification (WN) issued June 6, 2024.
Inspection #2024-1336-0001 - Compliance Order (CO) with $5,500 AMP, issued April 3, 2024.
Inspection #2023-1336-0004 - CO issued January 11, 2024.
Inspection #2023-1336-0002 - WN issued February 6, 2023.

This is the second 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

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.