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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: August 8, 2024
Inspection Number: 2024-1120-0004
Inspection Type: Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Kapuskasing, Kapuskasing

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 8-10, 2024.

The following intakes were inspected:

- One follow-up intake for CO #001 related to Nutritional care and hydration programs
- One follow-up for CO #002 related to Additional training-direct care staff
- One intake related to a COVID-19 Outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1120-0002 related to O. Reg. 246/22, s. 261 (2) 1.

Order #001 from Inspection #2024-1120-0002 related to O. Reg. 246/22, s. 74 (2) (a)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

Non-compliance with: FLTCA, 2021, s. 23 (4)

Infection prevention and control program

s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee has failed to ensure that the home had an Infection Prevention and Control (IPAC) Lead whose primary responsibility was the home's IPAC program.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (15) 1., the home was required to have an IPAC Lead who worked 17.5 hours per week on site, in the home.

At the time of the inspection an IPAC Lead was not observed to be in the home.

The Administrator confirmed that the home did not have an IPAC Lead and that no

one in the home was assigned to fulfill the IPAC Lead's role requirements.

Failure to ensure that there was an IPAC Lead to fulfill the required role and responsibilities, put residents in the home at risk.

Sources: Observations in the home, IPAC Standard for LTCHs, revised September 2023, and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Ministry of Health (MOH), April 2024; and interviews with a registered staff member, Director of Care (DOC), and Administrator.

This Written Notification is being referred to the Director for further action by the Director.

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The Licensee has failed to ensure that cleaning and disinfection was in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there were none, in accordance

with prevailing practices.

Rationale and Summary
During the inspection, open and expired containers of disinfectant wipes were observed in the home.

The Administrator stated that expired disinfectiant wipes should not be in use; however, no process was in place to ensure that they were not used.

When the home failed to ensure that a process was in place to prevent expired disinfectant products from being used in the home, there was risk to the residents that contact surfaces were not effectively cleaned and disinfected.

Sources: Observations; public health unit (PHU) inspection reports, "PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings: 3rd Edition, April 2018", and the licensee's policies; and interviews with a PHU Inspector and the Administrator.

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was notified immediately, when a respiratory outbreak was declared in the home.

Rationale and Summary
A COVID-19 outbreak was declared in the home by the local PHU. The home did not submit a Critical Incident (CI) report to the Director until two days later.

The Administrator acknowledged that they were not aware of the outbreak management processes or the legislative requirements for reporting, so they were unaware that the report was submitted late.

Failure to notify the Director immediately when a COVID-19 outbreak was declared in the home may have placed resident safety at risk due to a lack of transparency and communication with the Director.

Sources: CI report and the licensee's policy; and interviews with the Administrator and a registered staff member.

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee has failed to ensure that any updates as requested by the Director were provided, when a respiratory outbreak was declared in the home.

Rationale and Summary
A COVID-19 outbreak was declared in the home by the local PHU.

The Director requested that the CI report be amended on specific dates to provide an update on the outbreak, as well as whenever any new cases were identified. The CI report was finalized 18 days later, with no amendments made since the initial submission. The finalized submission included new cases.

The Administrator acknowledged that the CI reports were not amended as required; that they were not aware of the legislative requirements to update the report with the requested amendments within the time frames specified.

Failure to provide updates on the outbreak in the home, as requested by the Director, may have put the residents' safety at risk, due to a lack of transparency and communication with the Director.

Sources: CI report, the licensee's policy; and interviews with the Administrator and a registered staff member.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee shall:

1) Educate and re-train all nursing and non-nursing staff, including the leadership team, who are responsible for conducting IPAC audits in the home, on the licensee's hand hygiene policy and personal protective equipment (PPE) policy related to auditing frequency; and, on the requirement to audit at least quarterly, IPAC practices in the home to ensure that all staff can perform the IPAC skills of their role, as required by Additional Requirement 7.3 of the IPAC Standard for Long-Term Care Homes (LTCHs), revised September 2023.

2) Keep record of the education provided, including the date of the education, the name of the person(s) who provided the education, if relevant, and the names and signatures of the staff who attended.

3) Create and implement a documented plan to conduct at least one audit of IPAC practices in the home, as well as the required number of hand hygiene and PPE donning and doffing audits during non-outbreak and outbreak situations, for at least two months following the service of this order, or until the home has no further concerns. This plan must specify who will conduct the required audits as well as the training provided to support their competency.

4) Keep record of the completed audits and any corrective actions taken. The records must include the date and time of the audits, as well as the auditor's name(s).

Grounds

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

1) Specifically related to auditing IPAC practices.

Rationale and Summary
There was a COVID-19 outbreak at the home.

The home was asked to provide copies of all IPAC audits completed within the previous quarter and through the end of the outbreak. The home provided two hand hygiene audits and one PPE donning and doffing audit. The audits had no dates, times, or names of those who completed them. The home did not provide any other audits.

According to a review of "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", weekly IPAC audits were to be conducted for the duration of the outbreak.

A registered staff member and the Administrator acknowledged that IPAC audits were not completed as required.

Failure to ensure that IPAC audits were completed by the home as required put residents at risk because gaps in IPAC practices may not have been identified, therefore could not be addressed.

Sources: Notes from outbreak meeting, the licensee's policies, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, April 2024, and the IPAC standard for Long-Term Care Homes (LTCHs), revised September 2023; and interviews with a PHU Inspector, a registered staff member and the Administrator.

2) Specifically, related to the resolution of an outbreak.

Rationale and Summary
According to Additional Requirement 4.3 of the IPAC standard for LTCHs, the licensee was to ensure that following the resolution of an outbreak, the outbreak management team (OMT) and the interdisciplinary IPAC team, conducted a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of the findings was to be created to make recommendations to the licensee for improvements.

The local PHU declared a COVID-19 outbreak at the home.

The Administrator acknowledged that after the outbreak was resolved, the home did not hold a debriefing session with the OMT to go over the outbreak, the PHU recommendations made throughout the outbreak, and the IPAC practices that were effective and ineffective in the managing the outbreak.

Failure to ensure that a debrief session to assess IPAC practices for effectiveness during the outbreak in accordance with the Director's IPAC Standard for LTCHs, posed a moderate risk to residents.

Sources: CI report, PHU notes during the outbreak, the licensee's policy, and the IPAC Standard for LTCHs, revised September 2023; and interviews with a registered staff member, a PHU Inspector, and the Administrator.

This order must be complied with by October 15, 2024

COMPLIANCE ORDER CO #002 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 (11)

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

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

The licensee shall:

a) Conduct a documented review of the licensee's policies and protocols related to outbreak management, including those specific to infectious diseases. The home's leadership team must complete the review and keep a record of the names and dates of those who participated, as well as any changes made.

b) Develop a written 'Home-Specific Outbreak Plan' as part of the outbreak management system at the home, using the licensee's template as identified in the licensee's outbreak management policies, to guide staff in responding to and managing an infectious disease outbreak. A record of who participated in the plan's development, the dates it was developed, and the name(s) of the person(s) in charge of the plan's annual review and revision, must be kept.

c) Provide in-person education/re-training as relevant to their positions, for all personal support workers, registered staff, housekeeping staff, non-nursing staff, and the leadership team on the outbreak management system's program and policies, as well as the written 'Home-Specific Outbreak Plan'. The education should

cover but not be limited to surveillance, declaring and managing an outbreak, outbreak management team (OMT), and the COVID-19 policy, as applicable to the staff members' roles. Ensure that the in-person training includes a comprehensive review, as applicable to each discipline, of the following requirements during an outbreak, as well as the process for accessing these outbreak related resources during an outbreak:
- Required IPAC education;
- Additional precautions and indications for implementation, including signage;
- Reporting requirements to the local public health, and the MLTC, including when amendments are requested by the Director; and
- OMT requirements throughout an outbreak and post outbreak.
The home must keep a record of the education provided, including the dates, the names of the individual(s) who provided the education, and the names and signatures of the staff members who attended.
d) Create and implement a process to test comprehension of the education provided.
e) Create and implement a written plan to self-evaluate compliance with the 'Home's Specific Outbreak Plan', including a backup plan in case the home's IPAC Lead or leadership team is unavailable during an outbreak.

Grounds
The licensee has failed to ensure that the home complied with the outbreak management system, including a written plan for responding to infectious disease outbreaks, as set out in Ontario Regulation (O. Reg. 246/22) 102 (11).

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the outbreak management system and that they were complied with.

1) Specifically, staff did not comply with the licensee's policy for reporting protocols to the local PHU, as required by the Health Protection and Promotion Act (HPPA).

Rationale and Summary
The licensee's policy titled, "Declaring an Outbreak", stated that staff must be aware of when symptoms meet the criteria for an outbreak, identify the outbreak promptly, notify the local PHU immediately, and follow all of their directives. Furthermore, the licensee's "COVID-19" policy, stated that staff were to follow any local PHU directives to prevent the spread of COVID-19.

The home notified the local PHU about one of its residents' COVID-19 symptoms. The PHU determined that two residents with symptoms or a positive PCR test were required to meet the outbreak case definition, and the home was instructed to report any additional cases. The home identified additional symptomatic residents however, they were not reported to the PHU until three days later.

The Administrator confirmed that the staff did not notify the PHU of the additional cases as required.

Failure to ensure that the public health reporting protocols were followed related to additional cases of symptomatic residents in the home, put the safety of other residents' at risk due to a delay in declaring and implementing the necessary measures to prevent the spread throughout the home.

Sources: Line listing for outbreak, licensee policies titled, "COVID-19", "Surveillance", "Outbreak Management Team", and "Declaring An Outbreak", email communications, and "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, MOH", April 2024; and interviews with a registered staff member, a PHU inspector, and Administrator.

2) Specifically, the home did not comply with the licensee's policy to establish a written outbreak plan, as part of its Outbreak Management System, based on the requirement outlined in O. Reg. 246/22, 102 (11) (b).

Rationale and Summary
The licensee's policy titled, "Outbreak Management Team", directed the home to develop a home specific outbreak plan to be implemented during an outbreak and to be reviewed and revised at least yearly, after any confirmed outbreak, when gaps were identified, or as needed, using the template provided in the Appendices of the policy. The template identified several details that needed to be in the plan, such as controlling transmission within the home.

After several attempts to locate a written home-specific outbreak plan, the Administrator acknowledged that they did not have one; that they were unaware of the home's outbreak management policies, and thus unaware of what the home needed.

Failure to ensure that the home established a written home-specific outbreak plan to assist staff in responding to and managing the COVID-19 outbreak, put at risk the health and well-being of the residents and others who visited the home.

Sources: Licensee's policy, "Outbreak Management Team", email communications, and "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, MOH, April 2024; and interviews with a registered staff member, a PHU Inspector, and Administrator.

3) Specifically, the home did not comply with the licensee's policy to ensure that all staff completed mandatory COVID-19 related education when an outbreak was declared in the home.

Rationale and Summary

The licensee's "COVID-19" policy stated that when the PHU declared a COVID-19 outbreak, the Administrator/designate would ensure that staff completed any mandatory COVID-19 related education on the home's education platform. The policy also directed staff members to follow any other local PHU directives to prevent the spread of COVID-19.

The local PHU declared the home in a COVID-19 outbreak.

The home was unable to provide documentation demonstrating that any IPAC education was completed by the staff during the outbreak.

The Administrator confirmed that no records were kept indicating that staff had received other IPAC related training.

Failure to ensure that the home provided the required education as outlined in the licensee's policy and as recommended by the local PHU put residents at risk of not receiving the proper approaches to IPAC practices to mitigate the spread of COVID-19 during the outbreak.

Sources: Licensee policy titled, "COVID-19", email communications, PHU Inspection reports, and minutes of OMT notes; and interviews with a registered staff member, a PHU inspector, and Administrator.

4) Specifically, the home did not comply with the licensee's policy regarding the implementation of droplet/contact precautions for residents with COVID-19 symptoms.

Rationale and Summary

The licensee's policy titled, "COVID-19", directed staff to implement droplet/contact precautions for any resident who met the case definition of an Acute Respiratory Illness (ARI); that for residents with symptoms of COVID-19, staff were to take all necessary droplet and contact precautions.

The home reported to the local PHU that residents were experiencing COVID-19 symptoms; however, not all affected residents had been placed on droplet/contact precautions.

A registered staff member confirmed that incorrect additional precautions were implemented, with residents requiring isolation being initially placed on droplet precautions.

Failure to ensure that staff implemented additional precautions as outlined in the licensee's policy, increased the risk of transmission of COVID-19 transmission to residents, potentially contributing to the spread of the infectious disease throughout the home.

Sources: Line listing for outbreak, licensee policy titled, "COVID-19", notes from OMT meetings, and PHU inspection report; and interviews with a registered staff member, and a PHU inspector.

This order must be complied with by October 15, 2024

COMPLIANCE ORDER CO #003 CMOH and MOH

NC #007 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)]:
a) Develop and implement a process to ensure that all alcohol-based hand rub (ABHR) in the home is not expired.
b) Conduct monthly audits and take corrective action for any deficiencies found for two months or longer if concerns are identified, following the issuance of this order, of all resident and common areas to ensure that the ABHR is not expired. All completed audits must be documented, with a record kept that includes the auditor's name and date of the audit.

Grounds
The Licensee has failed to ensure that the alcohol-based hand rub (ABHR) in use in the home, was not expired.

Rationale and Summary
During the inspection, expired ABHR units were found in the dispensing units at 24 resident bed locations.

The DOC and the Administrator acknowledged that the home's ABHR had expired while it was in use. They confirmed this was an issue during the recent COVID-19 outbreak; that they believed it had been addressed at that time, but no formal process for checking expiry dates was implemented.

The failure to ensure that ABHR used in the resident rooms in the home had not expired, put residents at risk of infection from microorganism transmission.

Sources: Observations of resident rooms; PHU report, and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, April 2024; and interviews with a PHU, DOC, Administrator, and other staff members.

This order must be complied with by October 15, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.