Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
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Original Public Report

Report Issue Date: November 22, 2023	
Inspection Number: 2023-1171-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Laurier Manor, Gloucester	
Lead Inspector Martin Orr (000747)	**Inspector Digital Signature**
Additional Inspector(s) Saba Wardak (000732) Gurpreet Gill (705004)	

INSPECTION SUMMARY

This inspection occurred on-site on the following dates: November 7, 8, 9, 10, 2023.

The following intakes were inspected during this complaint inspection:

Intake: #00100842 complaint related to pest control.

The following intakes were inspected during this Critical Incident (CI) Inspection:

Intake: #00098054-CI:2665-000048-23-related to resident-to-resident alleged abuse.
Intake: #00098136-CI:2665-000049-23-related to resident-to-resident alleged abuse.
Intake: #00097797-CI:2665-000047-23-related to resident-to-resident alleged abuse.
Intake: #00097351-CI:2665-000045-23-related to resident care and services.
Intake: #00094556-CI:2665-000038-23-related to covid outbreak.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that Infection Prevention and Control standard issued by the Director was followed by staff related to hand hygiene as required by Routine Practices.

Rationale and Summary

The inspector observed that a staff member was serving morning beverages in the dining room area. The staff member took the straw from resident glass on a table, placed it in a new glass, and provided fluid beverage assistance to the resident. Observed that staff member did not perform hand hygiene after assisting resident with their beverage using a straw. The staff member wiped a resident mouth with their clothes protector and then removed it from the resident's neck. The staff member did not perform hand hygiene after contact with one resident and prior to wiping another resident's mouth with their clothes protector.

A staff member poured a drink in a glass for a resident who was sitting in their wheelchair in the west hallway and served it to them. At the same time, the same staff member moved the resident's used cup and then grabbed a jug and poured a drink for another resident and handed it to their caregiver. The same staff member did not perform hand hygiene after touching the used cup and prior to preparing and serving a drink to another resident.

A staff member was observed lifting a resident head and applying a clothes protector to resident who was in a wheelchair. Subsequently, the staff member applied a clothes protector to resident who was

also in a wheelchair and touched the wheelchair. Afterward, the staff member applied a clothes protector to another, who was also in a wheelchair and the staff member touched the resident's arm and adjusted a clothes protector, and then proceeded to another resident. After applying a clothes protector, the staff member adjusted their chair, walked towards the nursing office, and then assisted the resident in a hallway. The staff member did not perform hand hygiene before and after applying clothes protectors to different residents and before and after touching residents and their wheelchairs.

During an interview with the staff member, they confirmed that they forgot to sanitize their hands and indicated that they are supposed to sanitize their hands before and after touching residents, providing assistance to residents, and after touching dirty dishes. Another staff member also indicated that they did not perform hand hygiene before and after applying clothes protectors. The staff member indicated that they are supposed to sanitize their hands when applying clothes protectors between residents and before and after touching residents.

The Infection Prevention and Control (IPAC) Manager indicated that hand hygiene must be done according to the four moments of hand hygiene, before and after contact with the resident or resident's environment.
As such, a lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Observations made by the inspector and interviews with the IPAC Manager and two PSW's.
[705004]