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

Ottawa District
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Original Public Report

Report Issue Date: May 16, 2024	
Inspection Number: 2024-1171-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Laurier Manor, Gloucester	
Lead Inspector Gurpreet Gill (705004)	Inspector Digital Signature
Additional Inspector(s) Jessica Nguyen (000729) Inspector Sarah Bradshaw (740814) was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2, 3, 8, 9, 10, 11, 12, 16, 17, 18, 19 and 22, 2024

The following intake(s) were inspected:

- Intake: #00103669 [CI:2665-000057-23] related to -ARI - COVID 19 - Outbreak declared
- Intake: #00105029 [CI:2665-000060-23] related to COVID- 19 - outbreak declared
- Intake: #00106809 [CI:2665-000003-24] related to alleged resident to resident abuse
- Intake: #00106931: complaint related to insect infestation in the home

- Intake: #00107603 : complaint related to insect infestation and care and services
- Intake: #00107857 [CI:2665-000007-24] related to COVID 19 - outbreak declared
- Intake: #00110004 [CI:2665-000011-24] related to alleged resident to resident abuse
- Intake: #00110270 [CI:2665-000013-24] related to alleged staff to resident abuse
- Intake: #00111643 [CI:2665-000018-24] related to alleged resident to resident abuse.
- Intake: #00111697 [CI:2665-000019-24] related to a fall incident that caused injury to a resident and a significant change in condition
- Intake: #00111881 [CI:2665-000020-24] related to alleged staff to resident abuse

The following Inspection Protocols were used during this inspection:

Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

a)The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A Critical Incident System (CIS) report was submitted on a day in March, 2024 at 1359 hours to the Director related to an allegation of staff to resident emotional abuse that occurred on the previous day at 2110 hours.

The Assistant Director of Care (ADOC) indicated that the alleged incident of abuse was not reported immediately, Registered Nurse (RN) was required to inform the Director immediately.

As such, not reporting this incident of alleged abuse of the resident, could potentially place the resident at risk of not receiving appropriate follow-up.

Sources: Critical Incident System report and interview with the ADOC. [705004]

b)The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A Critical Incident System (CIS) report was submitted on a day in February 2024 at 1227 hours to the Director related to an allegation of resident to resident physical abuse that occurred on the previous day at 2000 hours.

A Registered Nurse (RN) indicated that they should have called the manager on call to get the directions to report the incident. The Assistant Director of Care (ADOC) indicated that the alleged incident of physical abuse was not immediately reported to the Director. The ADOC indicated that the RN should have called the manager on call, as a resident was punched by an unknown person and it should have been reported immediately.

As such, not reporting this incident of alleged abuse of the resident, could potentially delay their investigation.

Sources: Critical Incident System report and Interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (9) (b)

Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246 / 22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of a respiratory infection were recorded for a resident.

Rationale and Summary

The Infection Prevention and Control (IPAC) manager confirmed that the home experienced facility wide respiratory outbreak form April 02, 2024, until April 16, 2024, concurrently with suspected COVID outbreak.

A review of resident clinical records showed an onset of respiratory symptoms on a day in April 2024 and ending eight days after. A review of clinical records for the symptomatic resident confirmed that documentation of symptom monitoring for the period of eight days showed missing entries for symptom recording for three different shifts.

During an interview, an RN indicated that they monitor residents' symptoms every shift and it depends on the conditions and sometimes they monitor a resident more than once. IPAC manager indicated that registered staff are supposed to monitor and document symptoms every shift.

Failing to ensure that the resident's symptoms documented indicating the presence of an infection, increased the risk of medical complications related to potential delay in treatment.

Sources: the resident's health care records, interviews with identified staff members. [705004]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 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)]:
A) Educate all Personal Support Workers (PSWs), PSW students and Registered staff working on the fourth floor including full-time, part-time and casual basis staff on staff hand hygiene requirements, as per evidence based best practice standards.

B) Educate all Personal Support Workers (PSWs), PSW students and Registered staff working on the fourth floor including full-time, part-time and casual basis staff on resident and staff hand hygiene requirements during meal service, including requirements of staff to support residents with performing hand hygiene prior to meals, as per evidence based best practice standards.

C) Perform weekly audits to ensure that staff are following the licensee's Infection Prevention and Control Program with regards to: Hand Hygiene. The audits are to be completed until such time that the Ministry of Long-Term Care has deemed that the

licensee has complied with this order.

D) Perform audits on hand hygiene assistance to ensure residents are offered assistance with hand hygiene in the dining room. Conduct at a minimum, three times a week audits on each resident home area. Audits to be completed on separate days, alternating between different meals and different units. The audits are to be completed until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

E) Take corrective actions to address staff non-compliance related to hand hygiene as identified in the audits.

F) Keep written records of everything required under steps A, B, C, D and E of this compliance order, and must include; a copy of the education provided, those who attended with dates / times, as well as the name of the person who provided the education, a copy of the audits completed, as well as the name of the person who completed the audits, the dates and times of the audits, the unit and meal that was audited and any corrective action that was taken if deviation was identified during the audits. The written records of A, B, C, D and E shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
a)The licensee has failed to implement the IPAC Standard issued by the Director with respect to infection prevention and control (IPAC) measures for the resident hand hygiene.

Specifically, residents did not receive support from staff with hand hygiene prior to a lunch meal as required in the Hand Hygiene Program requirement 10.4 (h) under the

IPAC Standard.

On a day in April 2024, Inspector entered a specified home area and observed 16 residents sitting in the dining room. Over the course of 26 minutes, Inspectors observed staff bringing additional residents to the dining room, positioning and assisting them to dining tables and applying clothing protectors.

Inspectors observed two Personal Support workers (PSWs) serving drinks and soup to the residents. At this time, no residents had been offered assistance with hand hygiene of any sort upon entering dining room nor before starting to eat their meal.

A PSW indicated that Inspector should talk to the RPN, when inspector inquired about their process of hand hygiene in the dining room, an RPN indicated that they are supposed to wash resident's hand before they start eating and furthermore they indicated that mostly they do when they are bringing them to the dining room.

During an interview, IPAC manager indicated that staff are supposed to assist residents with hand hygiene before the meal.

A review of hand hygiene policy revealed that staff are encouraged or offered assistance to residents to properly wash or sanitize their hands before and after meals and snacks.

Not properly assisting residents with their hand hygiene before meal services increases the risk of transmission of infectious agents to residents.

Sources: Observations, a review of hand hygiene policy and interviews with identified staff members. [705004]

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

Specifically, the licensee did not ensure that Routine Practices included at a minimum, hand hygiene at the four moments of hand hygiene, as is required by Additional Requirement 9.1 (b) of the IPAC Standard.

On a day in April 2024, Inspector observed that a student Personal Support Worker (PSW) on a specified home area emptied a resident's meal plate and then placed it in a container for the dirty dishes. They then proceeded to the servery area and took clean paper napkins from the dietary staff. The student PSW did not perform hand hygiene after emptying dirty dishes and before picking up a clean napkin.

On another day in April 2024, Inspector observed that on the outbreak unit on a specified home area, a PSW brought a resident in a wheelchair into the dining room and positioned their wheelchair near the table. Then, the PSW proceeded towards another resident who was in a wheelchair and moved them to another table. The PSW did not perform hand hygiene between residents and walked down the east hall.

The same PSW brought a resident to the dining room and positioned them at the table and went to the nursing office. PSW did not perform hand hygiene after bringing resident in wheelchair and before opening the office door.

Inspector observed that an RPN applied a clothes protector to a resident, touched their hair, adjusted their wheelchair, released the wheelchair brakes and moved the wheelchair closer to the table. Then, they grabbed a second clothes protector and applied it to another resident, touched their shoulder, adjusted their clothes

protector and proceeded to a third resident, moving their walker to the side. The RPN took more clothes protectors and placed them on their arm, and applied one to the fourth resident, touched their neck area and moved their walker to the side. Then they proceeded to the fifth resident, and at same time picking up cutlery from the table and moving it for another resident. Afterward, they applied a clothes protector to a sixth resident, who was in a tilted wheelchair, and to a seventh resident at the same table. Afterwards, the RPN gave crackers to another resident, then proceeded to the servery area. The RPN was touching residents' wheelchairs, residents' hair, and neck area while applying clothes protectors and adjusting their wheelchairs and moving their walkers. The RPN did not perform hand hygiene between assisting different residents.

The student PSW indicated that they forgot to sanitize their hands. The PSW indicated that they forgot to wash their hands in between residents, and they were busy. During an interview, The RPN indicated that they did not sanitize their hands, they did not have time. They were busy and short staffed. They acknowledged that they are supposed to sanitize their hands between residents, but they did not have time.

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 and failure to follow the four moments for hand hygiene between resident interactions could increase the risk of infection transmission among residents and staff, when the home experiences a facility-wide respiratory outbreak and a suspected COVID outbreak.

Sources: Observations made by the inspector and interviews with identified staff members. [705004]

This order must be complied with by July 2, 2024

COMPLIANCE ORDER CO #002 Safe storage of drugs

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Perform at a minimum, one weekly audit on both day and evening shifts to ensure that registered nursing staff are locking the medication carts and their narcotic bins when unattended. The audits are to be completed until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this order.
B) Take immediate corrective action to address staff non-compliance with locking the medication cart when unattended.
C) Written records of A and B shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that drugs stored in an area or a medication cart are secure and locked.

On a day in April 2024, upon entering a specified home area, Inspector observed that a medication cart near the entrance of the dining room was unlocked and electronic Medication Administration Record (eMAR) screen was open with visible resident's information. There were no registered staff around the cart. An Registered Practical Nurse (RPN) was on the far side of the dining room administering medication to a resident. After administering a medication to a resident, the RPN went behind the wall in the dining room to discard the gloves. The medication cart was in the dining area while residents were in the dining room.

On the next day, upon entering the specified home area, Inspectors observed that an RPN was checking resident's blood glucose in the dining room. The medication cart was near the servery area and was unlocked. Residents were in the dining room.

Soon after, Inspectors observed that the medication cart in front of the elevator on the specified home area was not locked. There were no registered staff around the medication cart. The medication cart was unlocked and the Inspector was able to access all the medications including narcotics. The residents were in the dining room and walking near the medication cart. An RPN, came from the servery area and took the medication cart.

During an interview, the RPN indicated that they forgot to lock the medication cart and they are supposed to lock it. During separate interviews with two other RPNs, they indicated they are supposed to lock the medication cart.

The Assistant Director of Care (ADOC) indicated that registered staff have to lock the medication cart when they leave it. Furthermore, they indicated that after preparing medication and before going to the resident, they have to lock the medication cart.

A review of the medication management policy indicated to ensure medication cart is locked when unattended or out of sight. Lock eMAR screen prior to leaving cart to ensure privacy and security of resident information.

Failure to ensure that the medication carts were locked when not in use increased the risk for residents to be able to access medications and cause potential harm.

Sources: Observations, a review of medication management policy and interviews with identified staff members. [705004]

This order must be complied with by July 2, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.