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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 27, 2023
Inspection Number: 2023-1055-0003
Inspection Type: Complaint Critical Incident System
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare London, London

Lead Inspector	**Inspector Digital Signature**
Julie Lampman (522)	Julie Lampman Digitally signed by Julie Lampman Date: 2023.05.23 10:46:44 -04'00'

Additional Inspector(s) Christie Birch (740898)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 9, 13, 14, 15, and 16, 2023
The inspection occurred offsite on the following date(s): March 10, 2023

The following intake(s) were inspected:

- Intake: #00016663 - CIS #2173-000024-22 related to falls prevention and management.
- Intake: #00017186 - CIS #2173-000002-23 related to resident care.
- Intake: #00020793 - Complainant related to the home's Infection Prevention and Control program.
- Intake: #00016154 - Complaint related to neglect and reporting matters to the Director.
- Intake: #00015263 - Complaint related to admissions to the home.
- Intake: #00016331 - Complainant related to the use of bedrails, neglect, and reporting certain matters to the Director.

The following intake(s) were completed in this inspection:
Intake #00011005/CIS #2173-000019-22; Intake #00002430/CIS #2173-000013-22;
Intake #00006496/CIS #2173-000016-22; Intake #00005200/CIS #2173-000012-22; and
Intake #00016224/CIS#2173-000023-22 related to falls prevention and management.

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

Admission, Absences and Discharge
Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Restraints/Personal Assistance Services Devices (PASD) Management
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure the resident's plan of care provided clear direction regarding isolation requirements.

Rationale and Summary
Observation of a resident room noted there was enhanced precautions signage posted which indicated staff were to wear specific personal protective equipment (PPE) as they were under additional precautions.

Registered Practical Nurse (RPN) #118 stated the resident was on additional precautions not enhanced precautions. RPN #118 removed the enhanced precautions signage and posted additional precautions signage.

Sources:
Observations of IPAC practices in the home, and interviews with RPN #118 and other staff.
[522]

Date Remedy Implemented: March 7, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out every operational or policy directive that applied to the long-term care home.

Rationale and Summary
On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19.

Per section 9 of the Minister's Directive, licensees were required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for (LTCHs) in Ontario were followed.

The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, dated December 23, 2022, stated homes were to post signage at entrances and throughout the home that listed the signs and symptoms of COVID-19, for self-monitoring and steps that must be taken if COVID-19 was suspected or confirmed in any individual.

Observation of the home noted there was no signage posted at the entrance and throughout the home for passive screening and steps that must be taken if the individual failed the passive screening.

The Infection Prevention and Control (IPAC) Manager acknowledged there was only a white sheet of paper typed with signs and symptoms of COVID-19 outside their door. The paper was not in a visible location and did not indicate it was for self monitoring or the steps that must be taken if COVID-19 was suspected or confirmed in any individual.

The IPAC Lead posted signage at the entrance to the home and in the lobby which listed signs and symptoms of COVID-19 and stated anyone exhibiting signs or symptoms was not to enter the home.

Sources:
Observations of IPAC practices in the home, and interviews with the IPAC Manager.
[522]

Date Remedy Implemented: March 9, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Rationale and Summary
The licensee has failed to ensure that a residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A) Inspector #522 observed an unattended medication cart beside the elevator. The electronic Medication Administration Record (eMAR) was open with resident information visible. There were residents seated in the area. The nurse was observed in the lounge area with their back to the cart, giving a resident medication.

Registered Practical Nurse (RPN) #138 stated another nurse had been there when they left to give the medication, so they did not lock the eMAR.

B) On a separate occasion, Inspector #522 observed an unattended medication cart. The eMAR was open with resident information visible and a housekeeper was observed in the area.

RPN #139 was at the nurses' station and acknowledged they should have locked the eMAR screen.

The Senior Director of Care (SDOC) stated staff should lock the eMAR when the medication cart was unattended.

To leave the eMAR screen open and unattended posed a potential risk for a breech of resident's personal health information.

Sources:
Observations of medication carts on home areas, review of the home's "Medication Management" policy RC-16-01-07 last reviewed January 2022, and interviews with RPN #138, RPN #139 and the SDOC. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that a resident's continence plan of care provided clear direction regarding the resident's continence care.

Rationale and Summary
Review of a resident's care plan noted specific continence care was not included.

Personal Support Worker (PSW) #141 stated the resident required specific continence care. PSW #141 reviewed the resident's care plan and confirmed it did not indicate the specific continence care required.

The Clinical Coordinator (CC) stated registered staff were responsible to update a resident's care plan. The CC confirmed the resident required specific continence care and it should be included in a resident's care plan.

Sources:
Review of a resident's clinical record and interviews with PSW #141 and the CC.
[522]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary
On two occasions, a resident was observed in their room with a PASD in place.

Review of the home's policy stated in part, when the specific PASD was in use, direct care staff were to monitor the resident hourly and document the monitoring.

Review of the resident's Point of Care (POC) documentation survey report noted that documentation for monitoring of the PASD was not initiated until a week after the PASD was put in place.

The Support Services Manager (SSM) showed inspector that the PASD had been put in place a week prior to the initiation of the documented safety checks.

The Clinical Coordinator (CC) reviewed the POC documentation and stated safety checks for the resident should have started when the PASD was put in place.

Sources:

Observations of the resident, review of the resident's clinical records, the home's policy, and interviews with the SSM and the CC.
[522]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

1. The licensee has failed to ensure that a resident's plan of care was reviewed and revised when they had a Personal Assistive Services Device (PASD).

Rationale and Summary
On two occasions, a resident was observed in their room with a PASD in place. The resident stated when they were admitted to the home, they had requested the PASD.

The Support Services Manager (SSM) confirmed when the resident received the PASD.

The resident's care plan noted that the use of the PASD was added to their care plan approximately a month later.

Registered Practical Nurse (RPN) #139 acknowledged the resident did not have the use of the PASD added to their care plan until a month after they starting using the PASD.

The Clinical Coordinator (CC) stated the resident's care plan should have been updated under PASD.

Sources:
Observations of the resident, review of the resident's clinical records and interviews with RPN #139, the SSM, the CC, and other staff.
[522]

2. The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A Critical Incident System (CIS) report was received by the Director, related to an incident with a resident.

During an initial observation of the resident, specific interventions were noted in place to prevent the resident from wandering.

The resident's care plan noted the interventions were different than the resident's Treatment Administration Record.

The Senior Director of Care (SDOC) confirmed that the resident's care plan and treatment record had different interventions. They also confirmed that the resident's care plan and treatment administration record were not updated when the incident occurred with the resident, and that they would expect the care plan and kardex to be updated immediately after the incident to prevent a reoccurrence.

Resident was at risk related to the delay in the interventions put in place.

Sources:
Interviews with the SDOC; observations of the resident; record review of the resident's care plan, kardex, and a CIS report.
[740898]

3. The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A CIS report was received by the Director related to a resident's fall.

i) Review of the home's Falling Star/Leaf Flagging Guide dated January 2023, noted that "Residents in the program can be identified in one or more of the following ways: wrist band or visible clothing identified by the home, icon on bedroom door and/or near bed, and/or flag on chart."

During an initial observation of the resident's room and chart, no falling leaf logo was posted. A record review of the resident's care plan indicated that the resident was a risk for falls but did not indicate the resident was to be on the falling leaf program.

The Falls Lead confirmed that the resident was a risk for falls and should have had the falling leaf program and logo in place.

ii) The resident's care plan indicated that the resident required specific interventions for transfers, mobility and toileting.

Personal Support Workers (PSW) #103, #105 and #107 indicated that the resident required different interventions that were indicated in their care plan.

The Physiotherapist, and the Falls Lead confirmed that the care plan and kardex did not reflect the

current transfer, toileting and mobility status of the resident.

There was low risk to the resident at the time of inspection as the resident received the care they required based on assessments.

Sources:
Interviews with PSWs #103, #105 and #107, Falls Lead and Physiotherapist, observations of the resident, record review of care plan, kardex and Extendicare Falling Leaf/Star Flagging Guide dated January 2023. [740898]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A) The home's "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" policy noted that in the case where an allegation of abuse and neglect was made against an employee, management would immediately advise the employee that they were being removed from the work schedule, with pay, pending an investigation.

An allegation of neglect was made against a staff member.

The staff member's employee file noted no documentation of an allegation of neglect or that they would be off pending the investigation. The staff member's schedule noted the staff member worked, after the allegation of neglect was made.

The Senior DOC (SDOC) reviewed the staff member's schedule with Inspector #522 and acknowledged the staff member had worked after the allegations were made and stated the staff member should have been put off immediately pending the investigation.

There was risk to residents when a staff member accused of alleged neglect was not put off immediately pending the investigation.

B) The home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy noted in

part, that staff must complete an internal incident report and notify their supervisor upon suspecting or becoming aware of abuse and neglect of a resident.

The staff member who reported the incident of neglect indicated they had not documented the incident in risk management as they were waiting to speak with the DOC.

The CC stated the incident of neglect involving the resident and staff member should have been documented in risk management.

Sources:
Review of the home's risk management, the home's "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" policy RC-02-01-03 last reviewed January 2022, the home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy RC-02-01-02 last reviewed January 2022, and interviews with the CC, the SDOC and other staff.
[522]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee, was immediately investigated.

Rationale and Summary
A resident's progress notes indicated that registered staff found an area of altered skin integrity on the resident. The resident alleged a staff member had abused them resulting in an area of altered skin integrity. The registered staff member completed risk management regarding the incident.

The Administrator stated the DOC and CC were responsible to review risk management daily and the incident should have been investigated and documented by the DOC.

There was risk to residents by not investigating incidents of alleged abuse as there was potential for the same incidents to occur.

Sources:
Review of the resident's clinical record, the home's risk management reports, the home's "Zero

Tolerance of Resident Abuse and Neglect: Response and Reporting" policy RC-02-01-02 last reviewed January 2022, and interviews with RN #140, the CC, the SDOC, and the Administrator.
[522]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

Rationale and Summary
The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff that the licensee knew of, or that was reported to the licensee, was immediately investigated.

An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC) that alleged a resident was neglected by a staff member; that the alleged incident was reported to the Director of Care (DOC); and the DOC did not follow up on the allegations.

A staff member stated when an incident of alleged neglect of a resident occurred they had reported the incident to the DOC, but the DOC never got back to them.

Another staff member stated they had worked on the day the incident happened and management did not speak with them regarding the incident.

The Administrator stated the incident of neglect of the resident should have been investigated by the DOC and documented.

There was risk to residents by not investigating incidents of neglect as there was potential for the same incidents to occur.

Sources:
Review of complaints to the MLTC, emails to the DOC, the resident's clinical record, the home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy RC-02-01-02 last reviewed January 2022 and interviews with the CC, the Senior DOC, the Administrator and other staff members.
[522]

WRITTEN NOTIFICATION: Reporting Certain Matters To Director

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident occurred shall immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
A staff member stated that they had reported concerns related to a resident to the Registered Practical Nurse (RPN) and the RPN had not done anything which resulted in harm to the resident. The staff member stated they reported the RPN to the Director of Care (DOC) as they were concerned about the resident's care.

A review of Long-Term Care Homes.net noted there were no Critical Incident System (CIS) report submissions related to alleged improper care of the resident.

The Senior DOC (SDOC) stated a CIS report should have been submitted by the DOC for an allegation of improper care of the resident.

Sources:
Review of the resident's clinical records, and interviews with the SDOC and other staff.
[522]

WRITTEN NOTIFICATION: Reporting Certain Matters To Director

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
A) An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC) that alleged a resident was neglected by a staff member, that the alleged incident was reported to the Director of Care (DOC), and the DOC did not follow up on the allegations.

A staff member reported an incident of alleged neglect of a resident to the DOC and Clinical Coordinator via email.

The Clinical Coordinator (CC) reviewed the home's CIS report submissions and acknowledged that a CIS report had not been submitted related to the alleged neglect of the resident.

B) The resident's progress notes noted that an area of altered skin integrity was found on the resident. The resident alleged a staff member had abused them resulting in an area of altered skin integrity. The registered staff member submitted a risk management report due to the area of altered skin integrity.

The CC reviewed the home's CIS report submissions and acknowledged that a CIS report had not been submitted related to alleged abuse of the resident.

The Administrator stated the DOC should have submitted CIS reports related to the allegation of abuse and neglect of the resident.

Sources:
Complaint to the MLTC, review of the resident's clinical records, the home's risk management reports, and interview with the Clinical Coordinator, the Administrator and other staff members.
[522]

WRITTEN NOTIFICATION: Training

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

The licensee has failed to ensure that no staff of the home performed their responsibilities before they received training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
A staff member's Surge Learning report for 2022 noted the staff member had not completed training in the home's policy to promote zero tolerance of abuse and neglect of residents prior to commencing their duties.

The staff member stated they had never received training on the home's abuse and neglect of resident's policy.

The Clinical Coordinator (CC) reviewed the staff member's records in Surge Learning and confirmed the staff member had not completed training on the home's abuse and neglect policy.

There was risk to residents as the staff member had never completed training on the home's abuse and neglect policies and there had been several complaints about the staff member.

Sources:
Review of the home's Surge Learning training, the staff member's employee file and interviews with the staff member and the CC.
[522]

WRITTEN NOTIFICATION: Training

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

1. The licensee has failed to ensure that all staff received annual training on the home's policy to minimize the restraining of residents.

Rationale and Summary
The home's Surge Training Course Completion for Restraint Minimization and PASDs for Direct Care Staff noted that 94.3% (99 of 105) completed the required training for 2022.

The Senior Director of Care (SDOC) confirmed not all staff that were working in the home had completed the required PASD and restraint training for 2022.

2. The licensee has failed to ensure that all staff completed annual training on Infection Prevention and Control (IPAC).

Rationale and Summary
The home's Surge Training Course Completion for IPAC for 2022 noted 154/165 (93.5%) of staff completed the required training.

The Clinical Coordinator (CC) confirmed not all staff that were working in the home had completed the

IPAC training in 2022. The CC stated the report went to the Director of Care (DOC) of all staff that did not complete training for DOC to follow up.

Sources:
Review of the home's Surge Training Course Completion for IPAC for 2022, the home's 2022 Surge Training Course Completion for Restraint Minimization and PASDs for Direct Care Staff and interviews with the CC and the SDOC.
[522]

WRITTEN NOTIFICATION: Training

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in abuse recognition and prevention, at the intervals provided for in the regulations.

Rationale and Summary
O. Reg 246/22 s. 261 (2) states the licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act annually.

Review of Surge Learning Extendicare: Zero Tolerance of Resident Abuse and Neglect from January 1 to December 31, 2022, noted 93.3% of staff had completed the required training.

The Clinical Coordinator (CC) confirmed not 100% of staff that were working in the home had completed the required training in 2022, and should have.

Sources:
Review of the home's Surge Learning records and an interview with the CC.
[522]

WRITTEN NOTIFICATION: Bed Rails

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that where bed rails were used, the resident was assessed and the

resident's bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Rational and Summary
An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC) that a resident had bed rails installed on their bed and was not assessed prior for the use of the bed rails.

The home's "Bed Rail Safety" policy stated in part, upon consideration of bed rails a bed rail safety assessment was to be completed. Once the implementation was approved by the Bed Rail Lead or Director of Care (DOC) staff were to obtain a physician's order.

Observations of the resident in their room noted that the resident had a bed rail in place.

The Support Services Manager (SSM) showed Inspector #522 that they had documented when the resident's bed rail had been installed.

Registered Practical Nurse (RPN) #139 confirmed the resident did not have a physician's order for the bed rail or a bed rail assessment completed until a week after the bed rail was installed.

There was risk to the resident as there was no physician's order and a bed rail safety assessment had not been completed prior to the installation of a bed rail on the resident's bed.

Sources:
Observations of the resident, review of the resident's clinical records, the home's "Bed Rail Safety" policy RC-08-01-09 last reviewed January 2022, the SSM's notebook, and interviews with the resident, RPN #139, the SSM, the CC and other staff.
[522]

WRITTEN NOTIFICATION: Bed Rails

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)

The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Rationale and Summary
An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC) that a resident had

bed rails installed on their bed and was not assessed prior for the use of the bed rails.

The home's "Bed Entrapment Testing" policy noted in part, that the Director of Care was to notify the maintenance department of situations that would require a resident's bed to be retested, including any change in the bed system, such as bed rails. Maintenance was to test the bed for the seven zones of entrapment and document the results in the bed entrapment worksheet.

Observations of the resident in their room noted that the resident had a bed rail in place.

When asked if the resident's bed had been assessed for entrapment when their bed rail was installed, the Support Services Manager (SSM) stated the resident did not have a bed rail on their bed. The SSM showed inspector the home's Bed Entrapment worksheet which noted the resident's bed did not have bed rails.

There was no documentation that the bed had been retested for zones of entrapment when the bed rails had been installed.

There was risk to the resident as their bed had not been tested for zones of entrapment after the installation of a bed rail on the resident's bed.

Sources:
Observations of the resident, review of the resident's clinical records, the home's Bed Entrapment Testing policy RC-08-01-10 last reviewed January 2022, the SSM's notebook, and interviews with the resident, the SSM, other staff.
[522]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell a post fall assessment was completed in full.

Specifically, staff did not complete the initial neurological assessment which was part of the post fall assessment.

Rationale and Summary
A resident had an unwitnessed fall.

The Clinical Coordinator/Falls Lead acknowledged that an initial neurological assessment was required for the resident's fall.

The “Falls Prevention and Management Program” policy and the “Post Fall Management” policy stated that post fall "staff are to complete an initial physical and neurological assessment and if a resident hits head or is suspected of hitting head, eg. an unwitnessed fall, to complete Clinical Monitoring Record, Appendix 6."

There was no documentation of completion of the initial neurological assessment in the resident’s paper chart or Point Click Care (PCC) file.

There was increased risk that the resident, who had an unwitnessed fall, may have had worsening or new neurological issues that went unnoticed prior to being sent to the hospital

Sources: Resident’s PCC file and paper chart; “Fall Prevention and Management Program” Policy RC-15-01-01 dated January 2023; and interviews with the Falls Lead and RN.
[740898]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that on every shift, symptoms which indicated the presence of infection in residents were monitored.

Rational and Summary
A complaint was submitted to the Ministry of Long-Term Care regarding the home’s outbreak management during a COVID-19 and gastroenteric outbreak in January and February 2023.

During this time, five residents who were in isolation were missing isolation notes monitoring symptoms of infection at different times during their isolation period.

Registered Practical Nurse (RPN) #144 stated staff would document symptoms of infection in a resident’s progress notes when they were in isolation once per shift. RPN #144 stated a resident who had vomiting was isolated and monitored until they were 48 hours symptom free. RPN #144 confirmed there were missing isolation notes for the five residents.

Sources:
Review of clinical records for five residents and interviews with RPN #144 and other staff.
[522]

WRITTEN NOTIFICATION: Notification Re Incidents

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary
A) An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC) that alleged a resident was neglected by a staff member; that the alleged incident was reported to the Director of Care (DOC); and the DOC did not follow up on the allegations.

A registered staff member stated incidents of abuse and neglect should be reported to a resident's family, but they had not contacted the resident's family as the DOC stated they would follow up.

B) An incident of alleged abuse was documented in the resident's progress notes. There was no documentation that the resident's SDM was informed.

The Clinical Coordinator (CC) reviewed the resident's progress notes and acknowledged the resident's family had not been notified of the incidents and should have been.

Sources:
Review of the resident's clinical record, the home's risk management, the home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy RC-02-01-02 last reviewed January 2022, and interviews with the CC, the Senior DOC and other staff.
[522]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)

The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Rationale and Summary
The Administrator stated that they did not have any records that an evaluation had been completed of the zero tolerance of abuse and neglect of resident's policy and any changes and improvements that were required to prevent further occurrences of abuse and neglect in the home.

Sources:
Interview with the Administrator.
[522]

WRITTEN NOTIFICATION: Dealing With Complaints

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of a verbal complaint regarding the care of a resident.

Rationale and Summary
A staff member stated they had verbally reported their concerns regarding the care of the resident to the Director of Care (DOC). The staff member stated the DOC did not follow up on their complaint.

The home's complaints binder noted no documentation of a verbal complaint related to the care of the resident.

The Senior DOC (SDOC) stated if a complaint was made to the DOC regarding the care provided to the resident by a registered staff member the complaint should be documented. The SDOC stated they were unable to find any documentation related to the complaint.

Sources:
Review of the home's complaints binder and interviews with the SDOC and other staff.
[522]

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to the home's outbreak management in January and February 2023, when the home was in a COVID-19, RSV and gastroenteric outbreak.

The home's Critical Incident System (CIS) reports for outbreaks during the above timeframe noted the following:

A CIS was submitted by the home for an RSV outbreak 10 days after the outbreak had been declared at the home.

A CIS report was submitted by the home for an enteric outbreak three days after the outbreak had been declared at the home.

During this inspection, the home went into an enteric outbreak. A CIS report was submitted by the home a day after the outbreak was declared at the home.

The Infection Prevention and Control (IPAC) Manager stated they did not have the access to submit the CIS reports as the Director of Care (DOC) submitted all CIS reports. The IPAC Manager reviewed the CIS reports for the RSV and enteric outbreaks and confirmed they were not submitted on time.

The Senior DOC (SDOC) confirmed the CIS report was submitted a day late for the home's current enteric outbreak. The SDOC stated the IPAC Manager had now been given access to submit CIS reports.

Sources:
Review of CIS reports, and interviews with the IPAC Manager and the SDOC.
[522]

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 5.

The licensee has failed to ensure that two Critical Incident System (CIS) reports related to disease outbreaks in the home, included the correct name and title of the person who made the initial report to the Director.

Two of the home's CIS reports for disease outbreaks in the home, noted that both were submitted late. The report indicated the name and title of the person completing the report was the Infection Prevention and Control (IPAC) Manager.

The IPAC Manager stated they did not have access to submit CIS reports and had been away during the time the reports were submitted. The IPAC Manager reviewed the CIS reports and confirmed they did not submit the reports and that the reports would have been submitted by the Director or Care (DOC) as the DOC was the person who submitted CIS reports for the home.

Sources:
Review of CIS reports and interviews with the IPAC Manager and other staff.
[522]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

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

Rationale and Summary
Inspector #522 observed an unlocked and unattended medication cart. The nurse was observed in the lounge area with their back to the cart, giving a resident medication.

Registered Practical Nurse (RPN) #138 stated another nurse had been there when they left to give the medication, so they did not lock the cart.

The Senior Director of Care (SDOC) stated staff should lock their medication cart when unattended.

There was risk to residents by leaving a medication cart unlocked and unattended as there were residents in the area that could access medications in the unlocked cart.

Sources:
Observations of medication carts on home areas, review of the home's "Medication Management" policy RC-16-01-07 last reviewed January 2022, and interviews with RPN #138 and the SDOC.
[522]

COMPLIANCE ORDER CO #001 Nutritional Care and Hydration Programs

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg. 246/22 s. 74 (2) (a).

Specifically,
A) The home will complete education with all registered staff members assigned to the first floor on the home's policies related to dietitian referrals and hydration assessments.
B) A record must be kept of the training, including the contents of the training, the dates of the training, the name of the trainer, and the staff members who completed the training.

Grounds
The licensee has failed to comply with the home's nutrition and hydration policies related to dietitian referrals and hydration assessments, included in the required nutrition care and hydration program in the home, for a resident.

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 nutritional care and hydration program and ensure they were complied with.

Specifically, staff did not comply with the home's "Food and Fluid Intake Monitoring Policy" RC-18-01-01 last reviewed January 2022.

Rational and Summary
The home's "Food and Fluid Intake Monitoring Policy" stated, in part, that registered staff were to

complete a referral to the registered dietitian if a resident had consumed 50 percent (%) or less from all meals for three or more days; or demonstrated a significant change in their normal food pattern intake.

The policy also indicated that if a resident consumed less than their fluid target level for three consecutive days the nurse must complete a Nursing Hydration Assessment and refer the resident to the registered dietitian if signs or symptoms of dehydration were present.

A resident's progress notes indicated that the resident had been refusing meals and fluids. For two consecutive periods, progress notes indicated that the resident was below their daily fluid goal intake for three days.

The resident's Documentation Survey Report noted during the same time period, the resident demonstrated a significant change in their normal food pattern intake.

The resident's clinical record noted there were no nutritional or hydration assessments for the resident and a referral had not been sent to the dietitian.

Registered Practical Nurse (RPN) #144 stated that the resident had been refusing meals and confirmed that the resident was below their daily fluid intake for a total of six days. RPN #144 stated a fluid assessment had not been completed on the resident and the resident had not been referred to the dietitian and should have been.

There was actual risk to the resident as they had been declining food and fluids and the resident did not have an hydration assessment completed nor was the resident referred to the dietitian.

Sources:
Review of the resident's clinical records, the home's "Food and Fluid Intake Monitoring Policy" RC-18-01-01 last reviewed January 2022, and interviews with RPN #144, RN #135 and other staff.
[522]

This order must be complied with by June 30, 2023

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

How the home will ensure there is coverage in the absence, including extended absences, of the Infection Prevention and Control (IPAC) Lead for a minimum of 26.25 hours per week.

Please submit the written plan for achieving compliance for inspection 2023-1055-0003 to Julie Lampman, LTC Homes Inspector, MLTC, by email to LondonDISTRICT.MLTC@ontario.ca by May 11, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

The licensee must be compliant with O. Reg 246/22 s. 102 (15) (2).

Specifically, the licensee must ensure that there is an Infection Prevention and Control (IPAC) lead who works regularly in the home 26.25 hours per week.

Grounds
The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead worked regularly 26.25 hours per week in that position on site at the home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary
Extendicare London had 170 beds and required an IPAC Lead that worked 26.25 hours per week.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to the home's outbreak management when the home was in a COVID-19, RSV and Gastroenteric outbreak.

The IPAC Manager stated they had been away during the outbreaks. The IPAC Manager stated the Clinical Coordinator (CC) would usually cover while they were off, but the CC was also away during that time.

The CC stated they were away during the outbreaks and confirmed when they returned to work the Director of Care (DOC) was no longer in the home and they covered the DOC, IPAC Manager and their own position for approximately two weeks.

The Senior DOC (SDOC) confirmed when the IPAC Manager was off there was no one in the IPAC Lead position 26.25 hours per week.

There was significant risk to residents by not having an IPAC Lead during the home's COVID-19, RSV and Gastroenteric outbreaks.

Sources:
Complaint to the MLTC, and interviews with the IPAC Manager, the CC and the SDOC.
[522]

This order must be complied with by May 22, 2023

COMPLIANCE ORDER CO #003 Infection Prevention and Control Program

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

The licensee must be compliant with O. Reg 246/22 s. 102 (2) (b).

Specifically, the licensee must ensure:
A) Four specific residents receive assistance with hand hygiene prior to meals.
B) Personal Support Worker (PSW) #120 and PSW #147 receive retraining on assisting residents with hand hygiene at meals and snacks.
C) PSW #122, Registered Practical Nurse (RPN) #121, RPN #144 receive retraining on the four moments of hand hygiene.
D) All staff receive retraining on how to properly perform hand hygiene.
E) PSW #145 and Registered Practical Nurse (RPN) #146 receive retraining on the home's Infection Prevention and Control Program.
F) Hand hygiene audits will be conducted weekly, until a Follow up inspection determines the home to be in compliance.
G) Conduct Personal Protective Equipment (PPE) audits on PSW #145 and RPN #146 to ensure they are donning PPE appropriately. Audits will be conducted weekly, until a Follow up inspection determines the home to be in compliance.
H) PSW #114 receives retraining on the proper cleaning of equipment for residents who are under droplet and contact precautions.
I) All training must be documented, including the name of the person who conducted the training, the name of the staff members who attended, the content of the training, and the date the training occurred.

Grounds
The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

A) Specifically, the licensee has failed to ensure that audits were used to determine when individual staff needed remedial or refresher training, as required by Additional Requirement 7.3 (a) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes (LTCHs), indicated under section 7.3 (a) that the licensee should ensure that the IPAC Lead planned, implemented, and tracked the completion of all IPAC training and assessments/audits and feedback processes were used to determine if staff had met training requirements as required by the Act and Regulation, or when individual staff needed remedial or refresher training.

The home's Hand Hygiene audit for 2023 noted deficiencies in the area of hand sanitizing. The audit indicated that 45.18 percent (%) of staff sanitized their hands for less than 20 seconds, which was below the recommended time frame.

The home's Personal Protective Equipment (PPE) Donning Audit-Contact Precautions Deficiency Summary noted 8.65% of staff did not don PPE appropriately. On five occasions it was noted that a Personal Support Worker (PSW) did not wear the required PPE.

The home's PPE Donning Audit-Droplet/Contact Precautions Deficiency Summary noted on two occasions Registered Practical Nurse (RPN) #146 did not wear PPE while administering medications to residents in isolation.

The home's 2022 Surge Training Course Completion for IPAC noted PSW #145 and RPN #146 did not complete the required training.

The IPAC Manager stated if the auditor identified an issue the auditor would do coaching in the moment. If it was a recurrent issue, then it was reported to the Director of Care (DOC) and the DOC was responsible to follow up. The IPAC Manager stated the DOC did not follow up on any of the noted deficiencies from the audits.

The Senior DOC (SDOC) stated follow up should have been completed with staff who did not wear PPE as required.

There was significant risk to residents by not retraining staff when IPAC audits noted concerns as the home was in an RSV, COVID-19 and Gastroenteric outbreaks during the time of the audits.

Sources:
Review of the IPAC Standard for LTCHs, the home's IPAC audits, the home's Surge Learning and interviews with the IPAC Manager, the SDOC and other staff.

B) Specifically, the licensee has failed to ensure that Routine Practices included environmental controls as required by Additional Requirement 9.1 (e) (i) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes (LTCHs), indicated under section 9.1 (e) (i) that the licensee should ensure that Routine Practices and Additional Precautions included the use of controls, including environmental controls, including but not limited to, location and or placement of residents' equipment and cleaning.

i) A resident was under additional precautions. A PSW stated they did not disinfect a lunch cart after exiting the resident's room and prior to bringing the cart back to the dining room as required.

ii) After utilizing an assistive device for a resident who was on additional precautions, staff members removed the assistive device from the resident's room. They left the device in the hallway without disinfecting the equipment as required.

As both staff members had left the area, Inspector #522 spoke with a PSW who was assigned to the home area. The PSW stated staff should have disinfected the equipment after using it.

Inspector #522 then spoke with another PSW who stated they had forgotten to disinfect the equipment and went and disinfected it.

The SDOC stated equipment that was used on a resident on additional precautions should be disinfected after use. The SDOC stated staff should not bring the dietary cart into the resident's room and that the cart should be left in the hallway and only the trays should be brought into the room.

There was risk of cross contamination by not disinfecting equipment used by a resident on additional precautions.

Sources:
Observations of the home's IPAC practices and interviews with PSW #114, PSW #115, the SDOC and other staff.

C) Specifically, the licensee has failed to ensure that Routine Practices included hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 (b) that the licensee should ensure that Routine Practices and Additional Precautions included hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

i) An RPN was observed attempting to administer medication to a resident. At no point was the RPN observed performing hand hygiene.

ii) A PSW was observed not wearing appropriate PPE and not sanitizing their hands as required.

iii) An RPN did not sanitize their hands after coming into contact with a resident's assistive device. They then went to their medication cart and continued with their duties not performing hand hygiene.

The IPAC Manager stated staff should sanitize their hands when donning personal protective equipment, and during medication administration. The IPAC Manager stated that it was the home's practice to have sanitizer on the medication cart when administering medications so it was easily accessible.

Staff not completing proper hand hygiene posed a risk of spreading healthcare associated infections.

Sources:
IPAC observations of the home and interviews with PSW #122, RPN #121 , RPN #144, the IPAC Manager and other staff.

D) Specifically, the licensee has failed to ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals and snacks required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes (LTCHs), indicated under section 10.4 (h) that the licensee should ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

i) Inspector #522 observed a meal service as residents were entering the dining room.

A PSW staff brought two residents to a table and helped them set up for their meal. However, the residents were not offered assistance with hand hygiene.

Inspector #522 spoke with four residents who all stated they did not receive assistance with hand

hygiene at meals. One resident stated to Inspector #522 that they had only received assistance because the Inspector was present.

ii) A PSW assisted a resident in the hallway, however they did not assist the resident with hand hygiene. The PSW stated they did not assist residents with hand hygiene during snacks.

Staff not assisting residents with proper hand hygiene posed a risk of spreading healthcare associated infections.

Sources:
IPAC tour of the home, and interviews with four residents, PSW #120, PSW #147 and other staff.

E) Specifically, the licensee has failed to ensure that Routine Practices and Additional Precautions included the proper use of Personal Protective Equipment (PPE), including the appropriate selection, application, removal, and disposal as required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes (LTCHs), indicated under section 9.1 (f) that the licensee should ensure that Additional Precautions included the proper use of PPE, including the appropriate selection, application, removal, and disposal.

i) A PSW was observed not wearing requiring PPE while they were entering and exiting a resident room and handling garbage.

ii) Review of the home's policy noted that staff were to place a hands free garbage receptacle inside a resident's room for easy disposal of PPE.

Inspector #522 observed a resident room with additional precautions signage posted and a small garbage bin without a lid was inside the door. A gown and face shield was sticking out of the garbage.

PSW #105 stated all residents on additional precautions should have a garbage bin with a lid. PSW #105 looked in the resident room and stated staff must have forgot to put a garbage bin with a lid in the room.

Inspector #522 observed another resident room with additional precautions signage posted and a small garbage bin without a lid was inside the door.

iii) a PSW staff remove their PPE incorrectly after exiting a resident room.

The IPAC Manager stated staff should have removed their PPE correctly and performed hand hygiene.

iv) A PSW was observed entering a residents room requiring additional precautions, however they were not wearing required PPE.

The IPAC Manager stated that staff should be wearing required PPE when entering a room for residents who were on additional precautions.

v) Signage noted the home was in a suspect COVID-19 outbreak on the second floor. Signage indicated that essential visitors and staff were to wear N95 masks and face shields on the floor.

Inspector #522 observed a PSW staff member not remove their PPE correctly when exiting and entering the unit after their break.

vi) Inspector #522 observed a staff member not wearing required PPE while on a unit that was in a suspect COVID-19 outbreak.

vii) A PSW was observed not removing their PPE correctly.

viii) A screener was observed not removing and re-applying PPE as required after performing rapid antigen tests.

The IPAC Manager stated the screener should have applied and removed their PPE as required.

There was risk of spreading health care associated infections when staff did not wear appropriate PPE or remove PPE correctly.

Sources:
IPAC Tour of the home, review of the home's "Droplet Precautions" policy IC_03-01-09 last reviewed January 2022, and interviews with PSW #105, PSW #107, PSW #115, Dietary Staff #148, Screener #119, the IPAC Manager and other staff.
[522]

This order must be complied with by June 6, 2023

COMPLIANCE ORDER CO #004 Dealing With Complaints

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with 0. Reg 246/22 s. 108 (1) 1.

Specifically,
A) The home must investigate the care of a specific resident.
B) The home must keep a record of the investigation, including but not limited to, the person(s) who conducted the investigation, records reviewed and interviews conducted.

Grounds
The licensee has failed to ensure that a verbal complaint made to the Director of Care (DOC) concerning the care of a resident was immediately investigated.

Rationale and Summary
A staff member stated they had reported to a registered staff member that the resident had a change in their normal intake. The staff member stated the RPN did not follow up with the resident. The staff member stated they had verbally reported their concerns regarding the care of the resident to the Director of Care (DOC).

The home's complaints binder noted no documentation of a verbal complaint related to the care of the resident.

The Senior DOC (SDOC) stated they were not aware of the complaint related to the care of the resident. The SDOC stated if a complaint was made to the DOC regarding care provided to the resident by a registered staff member the complaint should be documented and followed up. The SDOC stated they were unable to find documentation related to the complaint.

The Administrator stated they were not aware of the complaint and the DOC should have investigated the incident and documented it in the home's complaint binder.

By not investigating the complaint regarding the resident and determining if there was in fact improper care there was significant risk to other residents.

Sources:
Review of the home's complaints binder and interviews with the SDOC, the Administrator and other staff.
[522]

This order must be complied with by June 30, 2023

COMPLIANCE ORDER CO #005 Licensee to Stay in Contact

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 153 (1)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that the home maintains contact with any resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home.

The plan shall include but is not limited to:
A) How the home will ensure compliance with the legislation.
B) The person(s) responsible for monitoring that the process is being complied with, the frequency of monitoring and how it will be documented.
C) The person(s) responsible for implementing an action plan if monitoring demonstrates the process is not complied with.
D) Actions to address sustainability once the home has been successful in ensuring compliance.

Please submit the written plan for achieving compliance for inspection 2023-1055-0003 to Christie Birch, LTC Homes Inspector, MLTC, by email to LondonDISTRICT.MLTC@ontario.ca by May 11, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

This plan shall be implemented by the compliance due date: June 20, 2023.

Grounds
The licensee has failed to ensure that they maintained contact with a resident who was on an absence or with the resident's health care provider in order to determine when the resident would be returning to the home.

Rationale and Summary
A complaint was received related to the home refusing to readmit a resident back into the home from an absence with no explanation and the home refused to meet with the resident's representative or the current care team.

Progress notes noted that the resident was admitted to hospital and subsequently discharged from the home two months later. Progress notes indicated there was no communication between the home and hospital or resident the month prior to the resident's discharge from the home.

The Director at Home and Community Support Services confirmed that they had contacted the home by email with the goal to plan a care conference to further discuss this resident's care and the home was not willing.

The Senior Director of Care (SDOC) at the home acknowledged that they would expect the home to stay

in contact with the resident or hospital for the entire duration of the admission to hospital every few days and that the home had not done that.

The Social Worker (SW) at the home confirmed that there was no discharge planning done with the resident or hospital before discharge.

The hospital SW confirmed that the home did not contact the resident or hospital a month prior to the discharge from the home.

The lack of contact between the resident or healthcare provider and the home caused a high impact to this resident as they were discharged from the home and remained in hospital.

Sources:
Progress notes in Point Click Care; interviews with the SDOC, the SW, the Medical Director, the Director of Home and Community Care Support Services, and the Hospital SW.
[740898]

This order must be complied with by June 20, 2023

COMPLIANCE ORDER CO #006 Directives By Minister

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

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

The licensee must be compliant with FLTCA 2021 s. 184 (3)

Specifically, the licensee shall ensure that:

A) A Personal Support Worker (PSW) wears PPE as required.
B) The PSW receives retraining on the home's Infection Prevention and Control (IPAC) Program. The training must be documented including the content, the date and the name of the trainer.
C) Staff do not perform rapid antigen tests in resident areas, areas without the proper personal protective equipment or barriers to ensure resident safety.
D) The home conducts regular IPAC self assessment audits, including weekly when the home is in outbreak and every two weeks when the home is not in outbreak.
E) The home immediately notifies the Middlesex London Health Unit of potential outbreaks, including but not limited to COVID-19.

F) Residents with signs and symptoms associated with COVID-19 receive PCR tests as soon as possible after they develop, or as directed by the home's local Public Health Unit.
G) Residents with signs and symptoms associated with COVID-19 are isolated immediately and remain in isolation as directed by the home's local Public Health Unit.
H) Staff who work on an outbreak floor take breaks separately from staff on other floors.
I) Residents are cohorted during outbreaks.

Grounds
The licensee has failed to ensure the home was a safe and secure environment for its residents when the home was in a COVID-19 and gastroenteric outbreak.

Rationale and Summary
On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19.

A complainant was submitted to the Ministry of Long-Term Care regarding the home's management of outbreaks in January and February 2023.

1) Minister's Directive: COVID-19 Response Measures for LTCHs updated August 30, 2022, stated that licensees were required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario were carried out.

The COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2022, stated the removal of masks for the purposes of eating should be restricted to areas designated by the home. Homes must ensure that all staff complied with masking requirements at all times, even when they were not delivering direct patient care, including in administrative areas. Masks must not be removed when staff were interacting with residents or in designated resident areas.

A) Inspector #740898 observed a staff member outside the nursing station, remove their PPE and perform a Rapid Antigen Test (RAT). There were no barriers around the staff member who performed the tests and residents and other staff members were present in the area.

After the staff member performed the RAT, the test strip was left on the cart, which was unattended outside the nurses' station, and observed to be there by the inspector for ten minutes after the staff member left the station.

Registered Nurse #104 confirmed with Inspector #740898 that all staff complete RATs at a cart outside the nurses' station.

The Infection Prevention and Control (IPAC) Manager stated staff should not remove their PPE and complete the RAT in front of the nurses' station in a resident home area and it was not acceptable for staff to leave their used test strips on the cart in the hallway where residents could touch them.

The Middlesex London Health Unit (MLHU) Public Health Nurse (PHN) #149 stated staff should not complete RATs on the floor as there was no partition and no way to ensure that residents would not come up to staff while they were completing their tests. PHN #149 stated RATs should be disposed of properly as they were biohazardous material and should not be open for residents to potentially touch.

B) Inspector #522 observed Personal Support Worker (PSW) remove their PPE in a resident area

The IPAC Manager stated staff should not remove their PPE in a resident area in resident areas especially in front of residents.

There was risk to residents by staff removing their masks in designated resident areas, especially since second floor was in a suspect COVID-19 outbreak at the time.

Sources:
IPAC observations in the home, and interviews with RN #104, the IPAC Manager and other staff.

2) Minister's Directive: COVID-19 Response Measures for LTCHs updated August 30, 2022, stated that licensees were required to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for LTCHs in Ontario.

The COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2022, stated homes must complete IPAC audits every two weeks unless in outbreak. When a home was in outbreak, IPAC audits must be completed weekly.

An RSV outbreak was declared in the home on December 24, 2022 and declared over on January 30, 2023

A COVID-19 outbreak was declared in the home on January 27, 2023 and declared over on February 16, 2023.

A gastroenteric outbreak was declared in the home on February 3, 2023 and declared over on February 22, 2023.

The IPAC Manager stated they were away during the outbreaks and they were unable to find any IPAC audits completed for this time. The IPAC Manager stated the last IPAC audit was completed on December 22, 2022 and audits should have been completed weekly when the home was in outbreak in January and February 2023.

There was risk to residents as the implementation and ongoing adherence to IPAC practices in the home was not being monitored.

Sources:
CIS Reports, and interview with the IPAC Manager.

3) The COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2022, stated homes must notify the local public health unit of all confirmed and probable resident cases of COVID 19, as soon as possible.

The Middlesex London Health Unit's (MLHU) Outbreak Summary Report for Extendicare LTCH noted for the home's COVID-19 outbreak the positive COVID-19 status of a resident was reported late to the MLHU. The report noted concerns with delayed and inaccurate reporting by the home.

The MLHU's Outbreak Summary Report for Extendicare LTCH noted on the MLHU was informed verbally that 14 residents were experiencing gastrointestinal symptoms, with the earliest date of onset as ten days earlier. When the MLHU received the home's line listing, it noted that 31 residents were experiencing gastrointestinal symptoms facility wide, with the earliest date of onset as nine days earlier. The situation was reviewed with Extendicare and a confirmed Gastroenteritis outbreak was declared facility-wide. The report noted concerns with challenging communication and delayed and inaccurate reporting by the home.

The IPAC Manager stated they would normally contact the Public Health Unit (PHU) about a potential outbreak and in their absence the Clinical Coordinator (CC) or the Director of Care (DOC) would be responsible to notify the PHU. The IPAC Manager stated the CC and the IPAC Manager were both away during the COVID-19 and Gastroenteric outbreaks and the DOC would be responsible to notify the PHU.

The IPAC Manager stated the MLHU should have been notified as soon as there was a symptomatic resident.

PHN #149 confirmed residents experiencing gastrointestinal symptoms were not reported immediately to them and the home failed to report when a positive COVID-19 test result was received for a resident experiencing respiratory symptoms.

PHN #149 stated that during the home's current suspect COVID-19 and gastroenteric outbreak that a cluster of symptomatic residents had been reported late. PHN #149 stated they reiterated reporting requirements with the home as four symptomatic residents had not been reported, with the initial symptomatic resident case being six days earlier.

Sources:

Review of MLHU's Outbreak Summary Report, the home's line listings and interviews with the IPAC Manager, PHN #149 and other staff.

4) COVID-19 Guidance: LTCHs Retirement Homes, and Other Congregate Living Settings for Public Health Units Version 9 – January 18, 2023, noted molecular COVID-19 testing (using a laboratory-based molecular test, e.g., PCR, or a rapid molecular COVID-19 test, such as ID NOW or GeneXpert) was recommended for symptomatic individuals associated with a highest risk setting. Rapid antigen tests (RATs) should not be used for residents and staff of highest risk settings who were symptomatic without parallel molecular testing.

A COVID-19 outbreak was declared on a specific home area and a gastroenteric outbreak was declared facility wide in the beginning of 2023.

The MLHU's Outbreak Summary Report for Extendicare LTCH noted concerns with inappropriate and/or delayed testing during the home's COVID-19 and gastroenteric outbreaks.

The home's Gastroenteric line listing noted the 35 residents who became symptomatic during a specific two week period had only received a RAT.

Of those residents, three residents had symptoms on the home area where there was a COVID-19 outbreak and had only received a RAT test.

Email communications between PHN #149 and the DOC noted the MLHU had declared a facility-wide Gastroenteritis Outbreak at the home and stated that all residents on the line list were to complete molecular testing immediately to rule out COVID-19 and isolate while results were pending.

In an email response from the DOC to PHN #149, the DOC stated they would not complete PCR tests on the residents or isolate the entire building while waiting on the results.

The IPAC Manager stated a PCR test should be completed on residents with signs and symptoms of COVID-19. The IPAC Manager stated there was a delay in testing on the weekends as tests were sent Monday to Friday. The IPAC Manager reviewed the home's gastroenteric outbreak line listing for January 2023 and stated residents who became symptomatic should have had a PCR test when they developed symptoms.

PHN #149 confirmed that they had requested all residents on the gastroenteric line listing have PCR tests completed to rule out COVID-19. PHN #149 stated the DOC did not reply until three days later and initially refused to have the residents tested as they had negative RATs. PNH #149 stated they were concerned as the home was also in a COVID-19 outbreak and two of the residents on the gastroenteric line listing actually tested positive for COVID-19 once they had a PCR test completed.

Sources:
Review of resident's clinical records, the home's line listings, email correspondence, MLHU's Outbreak Summary Reports and interviews with the IPAC Manager, PHN #149 and other staff.

5) The COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2022, stated homes were to abide by the requirements set out in the COVID-19 Guidance: LTCHs, Retirement Homes, and Other Congregate Living Settings for Public Health Units.

The COVID-19 Guidance: LTCHs, Retirement Homes, and Other Congregate Living Settings for Public Health Units dated January 18, 2023, stated all residents who were identified as a confirmed or a probable COVID-19 case must self-isolate on Additional Precautions for at least 10 days from symptom onset or date of specimen collection, if asymptomatic (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present.

When a resident was symptomatic residents must self-isolate and be placed on Additional Precautions, medically assessed, and tested. Swabs should ideally be collected from residents as soon as possible after they developed symptoms (e.g., within 48 hours). All symptomatic residents must be tested for COVID-19, even during non-COVID-19 outbreaks, using a laboratory-based molecular test or a rapid molecular test.

A) During this inspection, the home had a suspect COVID-19 outbreak and a gastroenteric outbreak.

The home's line listing noted that a resident had developed symptoms associated with COVID-19 and was put in isolation. The resident did not have a PCR test completed until three days later.

Three other residents also developed symptoms associated with COVID-19 and were placed in isolation. All three residents did not have a PCR test completed until three days later.

The IPAC Manager stated the home's practice was if a resident developed symptoms on a Friday evening or the weekend residents would not be swabbed for COVID-19 until Monday. The IPAC Manager stated the one resident should have been swabbed as their symptoms developed on days.

B) The home's Gastroenteric line listing noted a resident developed symptoms and was put in isolation for three days. The resident who resided on the floor which was in a COVID-19 outbreak had not had a PCR tested completed to rule out COVID-19.

PHN #149 stated they had expressed to the home concern that the resident had symptoms and was only isolated for three days, based on a negative RAT test.

C) The home's COVID-19 line listing noted four specific residents were COVID-19 positive.

i) One resident was not isolated as required based on their symptoms and before their test results had returned.

The IPAC Manager reviewed the resident's progress notes and acknowledged that the resident had a PCR test completed and was taken out of isolation before the results came back. The IPAC Manager stated they could not make sense of why the DOC removed the resident from isolation before their results were back.

ii) Another resident had symptoms associated with COVID-19. At that time the resident was not put into isolation or tested for COVID-19. The resident was not tested and put into isolation until nine days later, when they developed further symptoms associated with COVID-19.

The IPAC Manager stated that the resident should have been isolated and tested for COVID-19 when they initially developed symptoms associated with COVID-19.

iii) Another resident who had symptoms associated with COVID-19 was not isolated as required.

The IPAC Manager stated the resident should not have been taken out of isolation until their PCR results came back.

PHN #149 stated the home originally stated the resident's PCR test was negative and then stated public health called to say it was positive.

iv) Another resident stated to staff that they did not feel well. The resident was not put into isolation until the following day and was not tested for COVID-19 until three days later.

The IPAC Manager stated when a resident had signs and symptoms of COVID-19 or experienced gastrointestinal issues they were to be placed in droplet and contact precautions immediately. Residents could not exit isolation until they have a negative result and symptoms have been improving for 24 hours or 48 hours for gastrointestinal issues.

PHN #149 stated the home had completed their line list incorrectly as it indicated the wrong start date of one of the resident's symptoms. PHN #149 stated another resident should have been isolated and had a PCR test completed when their symptoms started.

Sources:
Review of nine residents' clinical records, the home's line listings, and interviews with the IPAC Manager, PHN #149 and other staff.

6) The COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2022, stated even if not under Additional Precautions, exposed residents within the outbreak area of the home should be cohorted separately from non-exposed residents.

Staff should remain in a single cohort per shift, wherever possible. If staff must work with more than one cohort during a single shift, it is recommended that staff work with unexposed residents first.

The home's "Managing an Outbreak" policy noted in part, during and outbreak the DOC was to review staffing, job routines and staff assignments and make revisions if needed. Staff were to provide service to one cohort of residents know to be colonized or infected with the same organism.

The MLHU COVID-19 Outbreak Control Measures for LTCHs for the home's current suspect COVID-19 outbreak stated to cohort staff when possible and dedicate staff to cases only and/or affected or unaffected units only.

A) Two staff member were observed to provide care on a specific wing to a resident who was on additional precautions, then leave and enter another wing. A Personal Support Worker (PSW) stated they were assigned to take care of residents on several wings of the home. Some of the residents were on additional precautions and some were not.

The Senior DOC stated the home had co-horting measures in place and staff were designated to the first, second and third floor. The Senior DOC stated staff on should be caring for the resident on additional precautions on their own wing as staff on the other wing could potentially spread COVID-19 from one wing to the other.

B) The IPAC Manager notified inspectors that there was a suspect COVID-19 outbreak on a specific floor in the home. The IPAC Manager stated that staff from the suspect outbreak floor and another floor were using the back of the first floor dining room that was partitioned from the rest of the dining room for their breaks. When Inspectors asked if staff from each floor were separated in the area, the IPAC Manager acknowledged there were no partitions between the staff from each floor and indicated they would have partitions put up so staff from the floor that was in a COVID-19 outbreak would be separate from staff on the other floor.

PHN #149 stated that the home should be co-horting staff during breaks and that staff from a different wing should not provide care to the resident on additional precautions.

Sources:
Observations of a resident, review of the home's "Managing an Outbreak" policy IC-04-01-03 last updated January 2023, and interviews with PSW #115, the IPAC Manager, the Senior DOC, PHN #149 and other staff.

7) The COVID-19 Guidance Document for LTCHs in Ontario, dated December 23, 2022, stated visitors must be actively screened and asymptomatic screen testing was to be completed for visitors prior to entering the home.

The IPAC Manager indicated that visitors were required to scan a QR code and answer the screening questions and the Screener completed swabbing on the visitors from 0900 to 1700 hours.

The Senior DOC stated when the Screener left the front doors of the home were left open and were locked after the night shift started after 2200 hours. After hours, visitors were to go up to the floors where registered staff would verify that they had passed the screening questions and complete a RAT test. The Senior DOC acknowledged that visitors were being tested on the resident home areas and waited in the resident home area until they received their test results. The Senior DOC acknowledged the risk to residents and stated they would change the practice to ensure that everyone was screened and swabbed as soon as they entered the building on the first floor and no one would go to the floors to be swabbed.

PHN #149 stated visitors completing RATs and waiting for results in resident areas put residents at risk. PHN #149 stated they had expressed concern to the home in November 2022 regarding the testing space on the first floor as residents were in area with individuals waiting for test results.

Sources:
Interviews with the IPAC Manager, the Senior DOC, PHN #149 and other staff.

8) The COVID-19 Guidance Document for LTCHs in Ontario updated December 23, 2022, states, “homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.”

Inspector #740898 observed Personal Support Worker (PSW) #134 taking temperatures of residents. PSW #134 told Inspector #740898 that they took each resident's temperature, documented it on a piece of paper and submitted the paper to the registered staff. PSW #134 stated they did not ask the residents if they had any signs or symptoms of COVID-19.

Registered Nurse (RN) #133 told Inspector #740898 that the PSW took resident temperatures and RN #133 would document the temperatures in each resident's electronic Treatment Administration Record and indicated if the resident passed or failed the screening. RN #133 stated they did not ask the residents if they had signs and symptoms of COVID-19 and they were aware the PSW also did not ask the resident if they had signs and symptoms of COVID-19.

The IPAC Manager told Inspector #522 that PSWs took the resident temperatures on the specific floor. The expectation was that the PSW was to ask the resident if they had symptoms or if the resident was not capable then the PSW would observe the resident for signs and symptoms of COVID-19.

Sources:
Observations of IPAC practices in the home, review of the COVID-19 Guidance Document for LTCHs in Ontario updated December 23, 2022, and interviews with PSW #134, RN #133, and the IPAC Manager. [522]

This order must be complied with by June 6, 2023

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.