

**Inspection Report under
the Long-Term Care
Homes Act, 2007****Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée****Long-Term Care Operations Division
Long-Term Care Inspections Branch****Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670**Public Copy/Copie du rapport public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 8, 2021	2021_593573_0021	009616-21, 011317- 21, 012156-21	Critical Incident System

Licensee/Titulaire de permisExtendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9**Long-Term Care Home/Foyer de soins de longue durée**Extendicare Medex
1865 Baseline Road Ottawa ON K2C 3K6**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 29, 2021, October 1, 4, 5 and 6, 2021

The Following logs were completed in this Critical Incident System (CIS) inspection:

- 1.Log #011317-21 related to staff to resident alleged physical abuse.**
- 2.Log #012156-21 related to resident to resident alleged physical abuse.**
- 3.Log #009616-21 related to forwarded resident's complaints.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aide and the residents.

During the course of the inspection, the inspector(s) reviewed critical incident report, resident health care records, relevant home policies and procedures, and other pertinent documents. The inspector(s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.

- 1 WN(s)**
- 0 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Légende

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

During a lunch meal service, the inspector observed a PSW enter and exit residents' room with droplet/ contact precautions without donning the required personal protective equipment (PPE). The inspector observed the PSW inquire with the resident regarding their choices for the meal with the display plates, while standing in close proximity to the resident. The failure to follow the Infection Prevention and Control (IPAC) practices posed an infection control risk to the staff and the residents.

Sources: Direct observation, interview with the PSW, the Director of Care and other staff interviews. [s. 229. (4)]

Issued on this 18th day of October, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.