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: June 26, 2023	
Inspection Number: 2023-1093-0005	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Medex, Ottawa	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature** Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.06.28 14:26:19 -04'00'
Additional Inspector(s) Margaret Beamish (000723) Shevon Thompson (000731)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13, 14, 15, 19, 2023

The following intake(s) were inspected:

- Intake: #00085739 CIS #2579-000007-23 Fall which resulted in significant change in health status.
- Intake: #00088738 CIS #2579-000014-23 Hypoglycemia event

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 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 comply with written policies related to falls prevention and management.

In accordance with O. Reg 246/22 s.11 (1) (b) the licensee is required to have policies as part of the Falls Prevention and Management Program and that they are complied with.

Rationale and Summary:
On a specific date, a resident experienced a fall which caused an injury resulting in a significant change in the resident's health status. Extendicare's Falls Prevention and Management Program policy directs staff to monitor vital signs every hour for four hours then every eight hours for 72 hours post fall. A review of the residents Electronic Health Record revealed the resident's blood pressure was monitored at 0210 hours and then again at 0450 hours.

When interviewed a RN (Registered Nurse) stated vitals are to be taken hourly for four hours and continued for 72 hours after a resident falls, but was unable to provide specific details on the assessment they completed for the resident after the fall. The clinical record was reviewed with the ADOC (Assistant Director of Care) who confirmed that the blood pressure was completed at 0210 hours and then at 0450 hours and stated it is the expectation for all the vitals including blood pressure to be done every hour.

Impact/Risk:
Lack of consistent vital sign monitoring increases the risk of resident health status deterioration being unnoticed by staff.

Sources:
Review of the residents Electronic Health Record, Extendicare Falls Prevention and Management Program RC-15-01-01, Appendix 6- Clinical Monitoring Record, and interviews with Registered Staff and ADOC.

[000731]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to the hand hygiene program.

Rationale and Summary:
On a specific date Inspector observed 23 residents entering a dining room either independently or brought in by front line staff. Out of the 23 residents, 20 residents were not provided either physical assistance with hand hygiene or prompting to perform hand hygiene prior to meal delivery.
During an additional observation Inspector observed 15 residents enter a main dining room. 13 residents did not receive physical assistance or prompting to perform hand hygiene prior to meal delivery.

When interviewed, a resident stated the residents have to remember to perform hand hygiene themselves and do not receive prompting from staff to perform hand hygiene prior to meals.
A staff member reported that front line staff are required to assist residents with hand hygiene prior to and after meals. Both a Registered Nurse and the Director of Care confirmed staff are expected to assist residents with hand hygiene upon entering the dining room prior to being served their meal.

Impact/Risk:
Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources:
Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, April 2014. MLTCIB Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022, observation of meal services, and interviews with front line staff, Registered Staff and the Director of Care.

[720483]