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: September 26, 2023	
Inspection Number: 2023-1093-0007	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Medex, Ottawa	
Lead Inspector Maryse Lapensee (000727)	**Inspector Digital Signature** Maryse C Lapensee Digitally signed by Maryse C Lapensee Date: 2023.09.29 14:51:11 -04'00'
Additional Inspector(s) Kelly Boisclair-Buffam (000724)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12, 14, 15, 2023

The following intake(s) were inspected:

- Intake: #00093409 - CI# 2579-000024-23 - Related to a fall of a resident resulting in injury and significant change in condition.
- Intake: #00095682 - CI# 2579-000025-23 - Related to alleged resident to resident physical abuse.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to additional precautions including proper use of PPE, appropriate selection, application, removal, and disposal; and hand hygiene program.

Rationale and Summary

#1
In the month of September 2023, Inspector #000724 observed the afternoon snack pass on the second floor. The inspector observed ten residents provided with a snack and none were offered assistance with hand hygiene. A Personal Support Worker (PSW) acknowledged that they are to provide assistance for hand hygiene to all residents prior to snack pass.

The Inspector also observed during the afternoon snack pass, that a PSW had not performed self hand hygiene between serving residents. The PSW acknowledged that they are to perform self hand hygiene between serving residents.

Both a Registered Practical Nurse (RPN) and Infection Prevention and Control Lead (IPAC) confirmed that frontline staff are expected to assist residents with hand hygiene prior to their snacks and that frontline staff are to perform self hand hygiene in between resident contact.

Impact/Risk:
By not performing hand hygiene there is an increased risk of disease transmission among residents and staff.

Sources:
Afternoon snack pass observation, IPAC Standard for Long Term Care Homes, April 2022, specifically Additional Recommended Standard 10.4 (h), interviews with IPAC Lead, PSW and RPN.
[000724]

#2
In the month of September 2023, Inspector #000724 observed two Personal Support Workers (PSW) for 20 minutes on a specific floor, entering and exiting a room. A contact precaution sign was posted at the entrance of the room. The Inspector observed that no hand hygiene was performed during this time, and no isolation gown was used.

Interview with RPN and IPAC Lead confirmed that staff are to wear isolation gowns and perform hand hygiene when providing care to residents on contact precautions.

Impact/Risk:
By not following Contact Precautions there is an increased risk of disease transmission among residents and staff.

Sources:
Observation entrance of a room, IPAC Standard for Long Term Care Homes, April 2022, specifically Additional Recommended Standard 9.1(d), interviews with IPAC Lead and RPN.
[000724]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (a)

The licensee has failed to ensure that when an incident occurs that causes an injury to a resident for which the resident is taken to hospital, to contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the residents health condition.

Rational and summary

A resident was sent to hospital in the month of July 2023, following a fall. The resident had received a surgical intervention and returned to the home several days later. The Critical Incident Report (CIR) was submitted on the day the resident return to the home.

The ADOC acknowledged that the home waited for the resident to return to determine their overall medical status prior to submitting a CIR and did not contact the family or hospital for an update within three calendar days of the incident occurring.

Sources:
Interview with ADOC and CIR
[000724]