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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 18, 2024	
Inspection Number: 2024-1369-0001	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Mississauga, Mississauga	
Lead Inspector Indiana Dixon (000767)	**Inspector Digital Signature** Indiana A Dixon Digitally signed by Indiana A Dixon Date: 2024.04.22 09:31:24 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): March 22, 26, 27, 28, April 2, 2024

The following intake (s) were inspected:

- Intake: #00101283 - [Critical Incident (CI): 2884-000022-23] related to Infection Prevention and Control (IPAC).
- Intake: #00103373 - [CI: 2884-000025-23] related to Infection Prevention and Control (IPAC).
- Intake: #00108208 - [CI: 2884-000003-24] related to Infection Prevention and Control (IPAC).
- Intake: #00104377 - [CI: 2884-000026-23] related to Falls Prevention and Management.

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The following intake (s) were completed in this inspection:

- Intake: #00102330 – [CI: 2884-000023-23] related to Falls Prevention and Management.

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

Infection Prevention and Control
Falls 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)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in their plan of care.

Rationale and Summary

Review of a resident's written plan of care identified that hip protectors were to be worn at all times. The resident was seen on a specific date without their hip protectors. This was confirmed by a member of the nursing team.

In a follow up observation on the same date, the resident was observed lying in bed with their hip protectors on.

Sources: Plan of care, observation, and confirmation from staff.

Date Remedy Implemented: March 28, 2024
[000767].

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) Program, related to hand hygiene for staff.

Rationale and Summary

A staff member was observed entering the facility on a specific date. The staff did not perform hand hygiene prior to entering their work area. The staff put away their personal items and still did not perform hand hygiene. The staff was made aware of the observation, and they still did not perform hand hygiene at that time.

In a follow up discussion with the staff, they acknowledged that they did not adhere to the home's IPAC practices. A member of the IPAC team indicated that the expectation is for all staff to follow the instructions given by the home.

Failure to perform hand hygiene as required may increase the risk of infection in the home.

Sources: Observation and interview with staff.
[000767]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift a resident was monitored for symptoms of infection in accordance with the IPAC standard issued by the Director under subsection (2).

Rationale and Summary
According to the IPAC Standard for Long-Term Care Homes (LTCHs) revised September 2023, section 3.1 (b) and (f), the licensee shall ensure that the following surveillance actions are taken: Ensuring that surveillance is performed on every shift to identify cases of healthcare acquired infections (HAIs), device-associated infections and Antibiotic Resistant Organisms (AROs), and ensuring that surveillance information is tracked and entered into the surveillance database or reporting tools.

A resident temperature summary and progress notes revealed that they were not monitored on every shift for symptoms of infection on a specific date. This information was confirmed by a member of the registered nursing team.

By not monitoring a resident on every shift for symptoms of infection, this may contribute to further health risks for the resident.

Sources: Interview with staff, resident temperature summary, and progress notes. **[000767].**