

Ministry of Long-Term Care Long-Term Care Operations Division Long-Term Care Inspections Branch Central East Service Area Office 33 King Street West, 4th Floor Oshawa ON L1H 1A1 Telephone: 1-844-231-5702 CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date	June 24, 2022				
Inspection Number	2022_1049_0001				
Inspection Type					
☐ Critical Incident Syste	em □ Complaint ⊠ Follow-Up	□ Director Order Follow-up			
☐ Proactive Inspection	☐ SAO Initiated	☐ Post-occupancy			
□ Other					
Licensee Extendicare (Canada) Inc. Long-Term Care Home and City Extendicare Scarborough, Scarborough					
Lead Inspector Amandeep Bhela (746)	Inspector Digital Signature				
Additional Inspector(s) Ana Best (741722) – Shadowing Fatemah Heydarimoghari (742649) - Shadowing					

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 6-10, 13 and 14, 2022.

The following intake(s) were inspected:

- Intake #004772-22 (Follow-up) related to abuse
- Intake #004771-22 (Follow-up) related to Infection Prevention and Control (IPAC)
- Intake #004770-22 and Intake # 004769-22 (Follow-up) related to dining and snack service

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Refe	erence	Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	73 (1)	2022_673672_0003 (A1)	001	746
O. Reg. 79/10	73 (2)	2022_673672_0003 (A1)	002	746
O. Reg. 79/10	229 (4)	2022_673672_0003 (A1)	003	746
LTCHA, 2007	19	2022_673672_0002	001	746
O. Reg. 79/10	98	2022_673672_0002	002	746



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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION [CMOH AND MOH]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 272

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the *Health Protection and Promotion Act* are followed in the home.

Rationale and Summary

On an identified date, PSW#100 was observed exiting a resident room wearing a surgical mask below their nose. PSW #100 indicated that they had received direction from the home indicating that they were allowed to wear their mask below their nose if they had trouble breathing.

IPAC manager confirmed that this is not the direction for the staff to follow and that they are required to ensure that their mask is covering their nose and mouth. Risk in failing to wear the surgical mask correctly increases risk of transmission.

Sources: observation and interview with PSW #100 and IPAC Manager. [746]