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

Toronto District
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Original Public Report

Report Issue Date: November 6, 2023	
Inspection Number: 2023-1049-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Scarborough, Scarborough	
Lead Inspector Ryan Randhawa (741073)	**Inspector Digital Signature** Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2023.11.07 13:11:56 -05'00'
Additional Inspector(s) Ramesh Purushothaman (741150)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10, 12 - 13, 16 - 20, 23 - 24, 2023

The following intake(s) were inspected:

- Intake: #00097861 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

Pain Management
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)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the current version of the visitor policy made under section 267 of this regulation, was posted in a conspicuous and easily accessible area of the home.

Rationale and Summary

It was observed that the visitor policy was not posted in the home. The Director of Care (DOC) was interviewed and indicated that someone removed it as it was posted before.

The policy was posted in the home the same day.

Failure to have the visitor policy posted in the home provided minimal risk to the residents.

Sources: Observations; Interview with the DOC.
[741073]

Date Remedy Implemented: October 12, 2023

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a fall prevention strategy was provided to a resident as specified in their plan of care.

Rationale and Summary

A resident was at risk of falls. The resident required a fall prevention strategy in place as indicated in the resident's plan of care. During observations, the resident was observed without the fall prevention strategy in place.

A Personal Support Worker (PSW) confirmed that the fall prevention strategy was not in place. A Registered Practical Nurse (RPN) confirmed that the resident required the fall prevention strategy as part of the resident's fall prevention strategies in the resident's plan of care.

The DOC confirmed that the staff members were expected to follow fall prevention strategies in the plan of care for the resident.

The resident was at increased risk of injury when the fall prevention strategy outlined in the plan of care was not in place.

Sources: Observation; resident's clinical records; interviews with PSWs, RN, RPN, and the DOC. [741073]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care for two residents was documented correctly.

Rationale and Summary

1. A Resident's plan of care indicated that they required a certain level of assistance for activities of daily living (ADLs). The resident's documentation survey report indicated that for multiple days in October 2023, PSW staff documented that they provided the resident with different levels of assistance for the

ADLs.

PSWs indicated that the resident required the level of assistance for ADLs as described in the plan of care. PSWs and the DOC acknowledged that staff provided the correct level of assistance on the multiple days in October 2023, but documented incorrectly.

Failure to ensure that the provision of the care set out in the plan of care for the resident was documented correctly provided minimal risk to the resident.

Sources: Resident's care plan; resident's documentation survey report; interviews with PSWs, and the DOC.
[741073]

Rationale and Summary

2. A second resident's plan of care indicated that they required a certain level of assistance for ADLs. The resident's documentation survey report indicated that for multiple days in October 2023, PSW staff documented that they provided the resident with a different levels of assistance for the ADLs.

PSWs indicated that the resident required the level of assistance for ADLs as described in the plan of care. PSWs and the DOC acknowledged that staff provided the correct level of assistance on the multiple days in October 2023, but documented incorrectly.

Failure to ensure that the provision of the care set out in the plan of care for the resident was documented correctly provided minimal risk to the resident.

Sources: Resident's care plan; resident's documentation survey report; interviews with PSWs, and the DOC.
[741073]

WRITTEN NOTIFICATION: Windows

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Rationale and Summary

During a tour of the home with the Environmental Services Manager (ESM), the windows in three resident rooms opened greater than 15 centimeters (cm) to the outdoors when measured.

The ESM acknowledged that this exceeded the legislative requirement for a window that opens to the outdoors when the windows opened more than 15 cm.

By having the windows in the home that opened to the outdoors more than 15 cm, it placed residents at risk for injury and elopement.

Sources: Observation; Interview with ESM, and the DOC.
[741073]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

Rationale and Summary

It was the process in the home for dietary staff to take the holding temperature of foods just before serving to ensure that hot foods were served and held for the duration of meal service outside the danger zone (above 60 degrees Celsius (C)/140 degrees Fahrenheit (F) and below 4 degrees C/40 degrees F).

Point of Service Food Temperature Records for the week of October 9 -15, 2023, defined required temperature of hot food to be 60 degrees C or 140 degrees F and cold food to be 4 degrees C or 40 degrees F. Review of these logs indicated the meal temperatures were being taken in both Celsius and Fahrenheit. On Tuesday, October 10, 2023, the temperatures for all hot foods were taken in Fahrenheit and the cold foods had a temperature in Celsius.

On October 12, 2023, the Food Service Supervisor took the temperatures of food items just as the lunch was served at the table. Hot foods, including pureed vegetables served measured 126 degrees F and vegetable-tomato potato curry measured 132 degrees F. Cold foods, including pureed desert, watermelon and dates squares measured 55.4, 51 and 59 degrees F respectively.

A Dietary staff indicated that the temperature may have changed due to the fact that the food was served in disposable containers. They also stated that there was a risk for food-borne illness when foods were served above 40 degrees F or below 140 degrees F.

The Dietary Manager indicated the temperature were only recorded at the time when the food was served in the plates and cups in the servery. They also stated that the temperature of the hot foods/ desserts was not checked before serving to the residents.

There was a risk of food-borne illness to residents when the cold food was held and served to residents at inappropriate temperatures.

Sources: Observations, home's policy and food temperature logs, interviews with the Dietary Manager and other staff.
[741150]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 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 the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC). The home has failed to ensure that Routine Practices were implemented in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene, including the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

(i) A PSW student was observed assisting residents with their clothing protectors prior to lunch. The student did not perform hand hygiene between coming into contact with residents while their hands were observed touching resident wheelchair head rests and resident hair and their shirts.

Physiotherapy staff was observed repositioning residents in their mobility assistive devices without performing hand hygiene in between touching the mobility assistive device. Both PSW student and the Physiotherapy staff acknowledged that they should have performed hand hygiene between contact with the different residents.

The IPAC Manager acknowledged that the staff expectation was to perform hand hygiene before and after assisting residents with care.

Failure to perform hand hygiene in between resident interactions increased the risk of infection transmission.

Sources: Observations, interviews with PSW Student and other staff.
[741150]

The licensee has failed to ensure that staff used appropriate personal protective equipment (PPE) in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, staff did not doff required Personal Protective Equipment (PPE) as per additional precaution 9.1 (d) under the IPAC standard.

Rationale and Summary

(ii) One of the residents in a semiprivate room of the home had additional precautions in place while the roommate did not. The residents' room door had additional precautions signage and donning/doffing posters to provide visual messages about additional precautions and sequence for putting/removing personal protective equipment (PPE).

A PSW was observed to provide care for the resident who was on isolation. Later the staff was observed to assist the other resident in the room with their personal care without removing the PPE.

Upon exiting the room, the PSW was observed to doff their PPE incorrectly, in the following order: gown, face shield and then gloves. The staff acknowledged that they did not follow correct doffing sequence upon exiting the resident's room.

The IPAC Manager acknowledged that the staff were expected to follow the correct donning and doffing procedures and the staff should have followed all appropriate IPAC practices.

There was risk of infectious disease transmission when the correct doffing procedure was not followed.

Sources: Observations, interviews with PSW and IPAC Manager.
[741150]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.

The licensee has failed to ensure that the Continuous Quality Improvement (CQI) initiative report included a written record of the date the survey required under section 43 of the Act was taken during the fiscal year, and how; and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, residents' council, and members of the staff of the home.

Rationale and Summary

Two documents titled Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario, and Quality Improvement Action Plan, both constituted as the home's Continuous Quality Improvement (CQI) initiative report, as described by the DOC.

The home's 2022 Resident and Family Satisfaction Survey Results indicated that the survey was conducted from October 31 to December 20, 2022.

The home's CQI initiative report for 2023 did not include a written record of the date the survey was taken during the fiscal year, and how, and the dates when, the results were communicated to the residents and their families, residents' council, and members of the staff of the home.

The Quality Risk Management Coordinator and the DOC confirmed that the CQI initiative report for 2023 did not include the aforementioned omitted written records.

Failure of the home's CQI initiative report to include a written record of the date the survey was taken and how, and the dates when, the results of the survey taken during the fiscal year were communicated to the residents and their families, residents' council, and members of the staff of the home provided minimal risk to the residents.

Sources: 2022 Resident and Family Satisfaction Survey Results; 2023 CQI initiative report (Quality

Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario, and Quality Improvement Action Plan) ; Interviews with the Quality Risk Management Coordinator and the DOC.
[741073]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.

The licensee has failed to ensure that the Continuous Quality Improvement (CQI) initiative report included a written record of the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, and members of the staff of the home.

Rationale and Summary

The home's CQI initiative report for 2023 did not include a written record of the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, and members of the staff of the home.

The Quality Risk Management Coordinator and the DOC confirmed that the CQI initiative report for 2023 did not include the aforementioned omitted written record.

Failure of the home's CQI initiative report to include a written record of the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, and members of the staff of the home, provided minimal risk to the residents.

Sources: 2023 CQI initiative report (Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario, and Quality Improvement Action Plan); Interviews with the Quality Risk Management Coordinator and the DOC.
[741073]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)

The licensee failed to ensure that a copy of the continuous quality improvement (CQI) initiative report was provided to the residents' council.

Rationale and Summary

The home's residents' council meetings minutes from December 2022 to September 2023 were reviewed and did not make reference to the residents' council being provided with a copy of the CQI initiative report.

Interview with the Resident Program Manager, who attended all the resident council meetings, confirmed that the residents' council was not provided with a copy of the CQI initiative report. The Resident Program Manager was unaware of the CQI initiative report.

Failure to ensure that a copy of the CQI initiative report was provided to the residents' council provided minimal risk to the residents.

Sources: Residents' council meetings minutes from December 2022 to September 2023; Interviews with the Resident Program Manager and the DOC.
[741073]