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

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Original Public Report

Report Issue Date: August 30, 2024
Inspection Number: 2024-1323-0002
Inspection Type: Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-16, 19-23, 26-28, 2024.

The following intake(s) were inspected:
· Intake: #00107571 - Improper/Incompetent treatment of a resident.
· Intake: #00114297 and Intake: #00118693 - related to Outbreaks.
· Intake: #00114479 -related to a fall of a resident resulting in a significant change in condition.

The following follow-up to Compliance Orders were inspected:
· Intake: #00111442 -CO #06 / 2024-1323-0001, O. Reg. 246/22 - s. 102 (9) (a), Compliance Due Date (CDD) April 30, 2024.
· Intake: #00111443 -CO #05 / 2024-1323-0001, O. Reg. 246/22 - s. 55 (2) (b) (ii), CDD April 30, 2024.
· Intake: #00111444 -CO# 04/ 2024-1323-0001, O. Reg. 246/22, s. 55 (1) 1, CDD April 30, 2024.
· Intake: #00111445 - CO #01/ 2024-1323-0001, FLTCA, 2021 - s. 6 (1) (c), CDD April 30, 2024.
· Intake: #00111446 -CO(HP) #003/ 2024-1323-0001, O. Reg. 246/22, s. 40, CDD

April 30, 2024.
· Intake: #00111447 -CO(HP)#:002/ 2024-1323-0001, FLTCA, 2021, s. 6 (4) (b), CDD April 30, 2024.
· Intake: #00111448 - CO(HP)#007/ 2024-1323-0001, O. Reg. 246/22, s. 104 (1) (a), CDD April 22, 2024.
· Intake: #00111449 -CO(HP)#008/ 2024-1323-0001, O. Reg. 246/22, s. 102 (2) (b), CDD April 30, 2024.

Previously Issued Compliance Order(s)

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

Order #007 from Inspection #2024-1323-0001 related to O. Reg. 246/22, s. 102 (9) (a)
Order #005 from Inspection #2024-1323-0001 related to O. Reg. 246/22, s. 55 (2) (b) (ii)
Order #004 from Inspection #2024-1323-0001 related to O. Reg. 246/22, s. 55 (1) 1.
Order #001 from Inspection #2024-1323-0001 related to FLTCA, 2021, s. 6 (1) (c)
Order #003 from Inspection #2024-1323-0001 related to O. Reg. 246/22, s. 40
Order #002 from Inspection #2024-1323-0001 related to FLTCA, 2021, s. 6 (4) (b)
Order #008 from Inspection #2024-1323-0001 related to O. Reg. 246/22, s. 104 (1) (a)
Order #006 from Inspection #2024-1323-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Orientation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 1.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in the Residents' Bill of Rights before performing their responsibilities.

The Administrator indicated confirmed that the RPN did not receive training in the Residents' Bill of Rights before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their

responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 2.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
2. The long-term care home's mission statement.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in the long-term care home's mission statement before performing their responsibilities.

The Administrator confirmed that the RPN did not receive training in the long-term care home's mission statement before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents before performing their responsibilities.

The Administrator confirmed that the RPN did not receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 4.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
4. The duty under section 28 to make mandatory reports.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in the duty under section 28 to make mandatory reports before performing their responsibilities.

The Administrator confirmed that the RPN did not receive training in the duty under section 28 to make mandatory reports before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 5.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
5. The protections afforded by section 30.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in the protections afforded by section 30 related to whistle-blowing protection before performing their responsibilities.

The Administrator indicated confirmed that RPN did not receive training in the protections afforded by section 30 related to whistle-blowing protection before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 6.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
6. The long-term care home's policy to minimize the restraining of residents.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in the long-term care home's policy to minimize the restraining of residents before performing their responsibilities.

The Administrator confirmed that the RPN did not receive training in the long-term care home's policy to minimize the restraining of residents before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 9.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in infection prevention and control before performing their responsibilities.

The Administrator confirmed that the RPN did not receive training in infection prevention and control before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1)

performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee has failed to ensure that no staff performs their responsibilities before receiving training in policies that are relevant to their responsibilities specifically in falls prevention and management and skin and wound care.

Pursuant to O. Reg. 246/22, s. 261 (1) 1, training shall be provided to all staff who provide direct care to residents, specifically, falls prevention and management.

Pursuant to O. Reg. 246/22, s. 261 (1) 2, training shall be provided to all staff who provide direct care to residents, specifically, skin and wound care.

Rationale and Summary

A review of the Surge training record indicated an RPN did not receive training in falls prevention and management and skin and wound care before performing their responsibilities.

The Administrator confirmed that the RPN did not receive training in the long-term care home's policy related to falls prevention and management and skin and wound care before performing their responsibilities.

Failure to ensure the RPN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for RPN #110 and an interview with the Administrator.

WRITTEN NOTIFICATION: ORIENTATION

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that staff received retraining in the policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

A review of the home's Surge Education records revealed that not all staff had completed the required re-education of the home's zero tolerance for abuse and neglect policy, in 2023.

The Administrator confirmed that five staff members did not complete the annual re-education regarding the home's zero tolerance for abuse and neglect.

Failing to re-educate all staff on the home's zero tolerance of abuse and neglect policy places residents' safety at risk.

Sources: Surge education record related to zero tolerance of abuse and neglect dated 2023; and an interview with the Administrator.

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee failed to ensure hazardous substances were kept inaccessible to residents at all times.

Rationale and Summary

During the inspection, oxygen tanks were observed stored in an alcove of the lobby. In addition, a fridge that was used to store specimens for lab pick up and a biohazard bin was stored in this area. The fridge was not locked and the lid of the biohazard bin was off.

The DOC acknowledge these items should not have been stored in the lobby and should be moved to areas that were inaccessible to residents.

The residents were put at risk of injury or exposure to infectious agents when the licensee failed to ensure hazardous items were inaccessible to residents

Sources: observations and interview with the DOC.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #011 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 shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

In accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023, Routine Practices and Additional Precautions states that at a minimum Routine Practices shall include:
9.1 e) Use of controls, including:
i. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

PIDAC: Routine Practices and Additional Precautions in All Health Care Settings | November, 2012, page 35, states "Droplet transmission occurs when droplets carrying an infectious agent exit the respiratory tract of a person". "Microorganisms contained in these droplets are then deposited on surfaces in the resident's immediate environment and some microorganisms remain viable for extended periods of time. Contact transmission can then occur by touching surfaces and objects contaminated with respiratory droplets."

Rationale and Summary

Glove caddies that held three boxes of gloves were observed to be hanging in all resident rooms. The majority of these caddies were mounted at the head of the

residents beds.

In an interview, the DOC acknowledge that gloves stored in the resident rooms posed an infection control risk.

Residents were put at risk of exposure to infectious agents when the gloves were mounted in resident rooms.

Sources: observations and interview with DOC.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance when disease outbreaks were declared in the home by the local Public Health Unit (PHU).

Rationale and Summary

The Director was not immediately notified of two separate outbreaks that had occurred.

The IPAC Lead indicated the Director was not immediately notified of the outbreaks and that they were now aware of the reporting requirement.

There was a low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: CIRs; interview with the IPAC Lead.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director related to improper/incompetent treatment of a resident that results in harm or risk to a resident.

Based on an observation by the Inspector, a review of the resident's clinical health records, and confirmation by an RPN, it was determined that a medication was not being administered to the resident as prescribed by the physician.

Failure to ensure that a medication was administered in accordance with the directions for use specified by the prescriber has placed the resident at risk for a negative outcome.

Sources: CIR, a resident's electronic health records, Inspector observation, and an Interview with the RPN.

WRITTEN NOTIFICATION: DESIGNATED LEAD

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 258
Designated lead
s. 258. The licensee shall ensure that there is a designated lead for the training and orientation program.

The licensee has failed to ensure that there is a designated lead for the training and orientation program

Rationale and Summary

The Administrator stated that the home did not have a designated lead for the training and orientation program.

Failure to ensure that there was a designated lead for the training and orientation program put residents' health and safety at risk due to lack of oversight of the

orientation and training needs of staff specifically staff who provide direct care to residents.

Sources: An interview with the Administrator.

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