Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 7, 2024	
Inspection Number: 2024-1328-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Lakefield, Lakefield	
Lead Inspector Marian Keith (741757)	**Inspector Digital Signature**
Additional Inspector(s) Catherine Ochnik (704957)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12-15, 20-23, 2024

The following intake(s) were inspected:

- An intake related to alleged resident abuse.
- An intake related to a complaint regarding resident safety and alleged staff to resident abuse.
- Two intakes related to disease outbreaks.

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

Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)
Infection prevention and control program
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee failed to have an infection prevention and control (IPAC) lead for a specific period of time.

Rationale and Summary:
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) for a communicable disease outbreak, which affected the whole home.

Outbreak Management Team Meeting Minutes documented the death of a resident. The death certificate of the resident identified the primary cause of death relating to the outbreak and the death was not reported to the Director in amendments to the

CI. The Case Definition List for the outbreak noted that the home met the case definition of an outbreak as per the home's policy before Public Health (PH) was notified.

The Director of Care (DOC) confirmed that the previous IPAC lead's final shift was on a specific date, and the current IPAC lead confirmed that they started their position on a later specific date. The DOC confirmed that the death of the resident was related to the outbreak and acknowledged that it should have been reported. The DOC acknowledged that PH should have been notified sooner of the residents that met the home's case criteria of an outbreak.

The failure to have a dedicated IPAC lead contributed to the delayed reporting to PH which impacted intervention and outbreak management in the home as the outbreak affected the entire home leading to the death of a resident which did not get reported to the Director.

Sources: CI report, Outbreak Management Team Meeting Minutes, resident's death certificate, home's policy, interviews with IPAC lead and DOC.
[741757]

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 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;

(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The licensee has failed to ensure that their new IPAC lead had the required education and experience upon commencement of their position.

Rationale and Summary:
The IPAC lead was required to have training in the following areas: infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology and program management. The IPAC lead indicated they were enrolled in an IPAC course that had not yet started. They were unable to provide documented evidence of receiving other formal education and training in the identified areas. The DOC confirmed that the IPAC lead has received some on the job training and that the IPAC lead was enrolled in an IPAC course.

By failing to have an IPAC lead that has the required training in IPAC practices, places the home at risk of not ensuring the appropriate implementation of the IPAC program.

Sources: Interviews with IPAC lead and DOC.

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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 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee failed to report to PH as soon as possible when two residents had symptoms that met criteria for outbreak according to the home's policy.

Rationale and Summary:
A CI report was submitted to the MLTC for a communicable disease outbreak. The CI report documentation revealed that PH was contacted on a specific date to notify for cases meeting outbreak criteria.

The Case Definition List for the outbreak in was reviewed and document indicated that two residents met the criteria for an outbreak with specific symptoms identified 24 hours apart, as per the home's policy.

The DOC acknowledged that PH should have been notified sooner of the residents that met the home's case criteria of an outbreak.

By not notifying PH of cases meeting outbreak criteria when identified, the home was at risk by delaying prompt intervention by PH in managing the outbreak.

Sources: CI report, home's policy, Interviews with DOC.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 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 failed to immediately inform the Director of a communicable disease outbreak.

Rationale and Summary:
A CI report was submitted to the MLTC for communicable disease outbreak.

The DOC confirmed that the expectation of the home was to immediately report an

outbreak to the Director.

Failure to submit the CI report within the expected timeframe had no impact to the residents.

Sources: CI report, Interview with DOC.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to inform the Director of a death of a resident related to an communicable disease outbreak.

Rationale and Summary:
A CI report was submitted to the MLTC for a communicable disease outbreak. The death of the resident relating to the outbreak was not reported to the Director in amendments to the CI.

Outbreak Management Team Meeting Minutes documented the death of the resident. The death certificate of the resident identified the primary cause of death was related to the outbreak. The DOC confirmed that the death of the resident was related to the outbreak and acknowledged that it should have been reported.

Failure to report the death to the Director impacted accuracy of reported data but had no impact to residents.

Sources: CI report, Interview with DOC.

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COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1). Provide in-person re-education to Janitor #106 and Housekeeper #108 on additional precautions, correct procedures and when to don and doff appropriate personal protective equipment (PPE).

2). Maintain a written record of training including the training materials, the date of training, name of staff attending with hand-written signature of the staff indicating understanding of training received, the name and title of the staff who provided the training.
3). Conduct an audit once per shift for Janitor #106 and Housekeeper #108 on IPAC practices related to donning and doffing PPE for 4 weeks by a registered staff and/or the IPAC lead. Analyze the audit results and provide on the spot education and/or corrective actions to Janitor #106 and Housekeeper #108 if any concerns are identified. Maintain a record of the audit and results, any education or corrective actions provided including the name and title of the auditor, the date and time of the audit being conducted.
4). Administer a supervised test to Janitor #106 and Housekeeper #108 post training. Ensure Janitor #106 and Housekeeper #108 complete the test independently and without aid. Ensure that if Janitor #106 and Housekeeper #108 receive a final grade of less than 90% on the test, they are provided with retraining and is retested on the materials. Maintain a documented record of the test materials and contents, all test results, the final grade as well as the date(s) the test(s) was administered.
5). Provide records identified from the above number one to number four and Janitor #106 and Housekeeper #108’s work schedule corresponding to the audit immediately upon request by inspectors.

Grounds
1.The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was complied with. Specifically, the licensee failed to support a resident with hand hygiene prior to their meal.

Rationale and Summary:
In accordance with the IPAC Standard for Long-Term Care Homes, April 2022, Additional Requirements Under the Standard, section. 10.4 directs the licensee to

ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as, under section 10.4 (h) support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

On a specific date, breakfast tray service for a resident was observed by inspector #741757. The resident was set up with the breakfast tray by PSW #105 and they left the room without offering hand hygiene to resident prior to eating their meal.

PSW #105 confirmed after the observation that they did not offer hand hygiene to the resident, but probably should. The resident confirmed that they were not offered assistance for hand hygiene prior to eating breakfast, and asked if staff were supposed to do this. The IPAC lead confirmed that the expectation of PSW staff was to ask residents if they need assistance with hand hygiene and assist them as required prior to eating when bringing meal trays to resident rooms.

Failure to assist residents with hand hygiene prior to meals increases the risk of transmission of germs or infectious agents from surfaces or objects directly to residents through the process of eating with unwashed hands.

Sources: Observation, Interview with resident, PSW #105, and IPAC Lead.

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2.The licensee failed to ensure that any standard issued by the Director with respect to IPAC was complied with. Specifically, the licensee did not apply appropriate PPE when entering residents' rooms with additional precautions.

Rationale and Summary:

In accordance with the IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1 (f) directs the licensee to ensure that Routine Practice and Additional Precautions are followed in the IPAC Program. At minimum, Additional Precautions shall include appropriated selection, application, removal and disposal of PPE.

The Long-Term Care Home was in a communicable disease outbreak at the time of inspection. Resident #006 and #007 both had signage outside of their rooms indicating they were on additional precautions. During the initial tour of the home, Inspector #741757 observed Janitor #106 enter resident #006's room without donning appropriate PPE as per additional precautions. Housekeeper #107 was observed by Inspector #741757 to enter resident #007's room without donning appropriate PPE as per additional precautions, as resident #007 was on a resident home area affected by the outbreak.

Janitor #106 confirmed that they were trained and should have put on PPE when entering resident #006's room. Housekeeper #108 indicated they did not have to wear full PPE when going into rooms with precautions when the resident was not in the room. Housekeeper #108 also stated it was their second day, and they had not worked on an outbreak unit before, and was doing what they thought they were told. Environmental Manager confirmed that the expectation was that the staff were to wear full PPE going into rooms with additional precautions whether the resident is in the room or not to ensure the safety of the staff going in and to prevent spread.

Failure to comply with the IPAC Standard requirement to proper donning of the PPE increased the risk of transmission of pathogens to themselves, other residents, and staff.

Sources: Observations, Interviews with Janitor #106, Housekeeper #107 and

Environmental Manager

[741757]

This order must be complied with by May 3, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.