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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
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Original Public Report

Report Issue Date May 30, 2022
Inspection Number 2022_1055_0001
Inspection Type
☒ Critical Incident System ☒ 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 London

Lead Inspector **Inspector Digital Signature**
Stephanie Morrison 721442

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 3, 4, 5, 6, 12, and 13, 2022.

The following intake(s) were inspected:

- Intake: 000147-22 Complaint related to skin & wound, dehydration, and pain management
- Intake: 001100-22 Critical Incident System (CIS) #2173-000003-22 related to falls prevention and management
- Intake: 003945-22 CIS #2173-000007-22 related to falls prevention and management

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)

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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. 272

The licensee has failed to ensure that the COVID-19 Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, effective May 3, 2022, was followed by not using the most current Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes to actively screen all persons who entered the home for symptoms of COVID-19.

Rationale and Summary
The COVID-19 Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, stated that homes must follow the most recent Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes to actively screen all persons for symptoms and exposure history for COVID-19 prior to entry to the home. The home was using an Extendicare screener questionnaire tool for active screening, which was missing symptoms of COVID-19 that were required on the Ministry of Health's screening tool.

The non-compliance was remedied by replacing the home's screening questionnaire tool with the most recent version, version 10 dated March 18, 2022, of the Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

Date Remedy Implemented: May 5, 2022 [721442]

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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)

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control (IPAC) was implemented by not having followed the IPAC Standard for Long-Term Care Homes, April 2022, regarding additional precautions.

Rationale and Summary

A) IPAC Standard Section 9.1 on Routine Practices and Additional Precautions stated the licensee must ensure that point-of-care signage indicating enhanced IPAC control measures were in place.

The proper signage was not in place indicating that a resident was on additional precautions with specific personal protective equipment (PPE) requirements.

In the morning on a specific date, a resident developed symptoms which required additional precautions. It was observed in the afternoon of the same date that no point-of-care signage was in place to indicate that the resident was on additional precautions requiring specific PPE. A staff member stated there should have been signage to indicate to staff and visitors that the resident was on additional precautions, and they had known about the additional precautions because the nurse told them that morning. The IPAC Lead stated they had been notified of the resident having been placed on additional precautions and put the appropriate signage up themselves in the afternoon of the same day the resident developed symptoms.

Delayed placement of point-of-care additional precaution signage increased risk that staff, residents, or visitors entered the resident's room without the required PPE to prevent the further spread of the home's COVID-19 outbreak.

B) IPAC Standard Section 9.1 on Routine Practices and Additional Precautions stated the licensee must ensure proper use of PPE, including the appropriate selection, application, removal, and disposal of PPE.

i) PPE was not properly removed after exiting two resident rooms.

Extendicare's PPE policy stated all staff were expected to dispose of all PPE into a hands-free garbage receptable before leaving a resident's room.

It was observed that a staff member had not removed their mask or eye protection after they assisted a resident, who had a known active COVID-19 infection, with their meal. The staff member stated they had known to remove their mask and eye protection, but they had forgotten to do so.

A staff member had not removed their mask and eye protection after completing a medication pass for two residents with additional precautions, one of the residents had a known active COVID-19 infection. The staff member stated they had been confused on what the expectations were for removing PPE when coming out of a room with additional precautions.

A staff member had not removed their mask when coming out of a resident's room who had a known active COVID-19 infection. The staff member stated they were not required to change their mask, only their face shield.

Improper removal of PPE coming out of a resident's room with a known active COVID-19 infection increased the risk of further spread of the home's COVID-19 outbreak to infect other residents, staff, and visitors.

ii) PPE was not properly disposed of after a screener left the surveillance screening area.

The IPAC Standard referenced the Provincial Infectious Diseases Advisory Committee (PIDAC), November 2012, guideline on Routine Practices and Additional Precautions In All Health Care Settings. Box #3 on page 13 of the PIDAC Guideline titled "Appropriate Gown Use", specified that isolation gowns were to be immediately disposed of into the appropriate receptable after removal, and to not be saved for later use.

It was observed that a screener stored their isolation gown on a chair while they left the screening area, and they re-wore the same gown when they returned. The screener stated they sometimes re-wore isolation gowns. The screener estimated that they had completed five or six rapid antigen surveillance tests while wearing the gown which they had not properly disposed of and had later re-worn.

Improper disposal of isolation gowns and the re-wearing of soiled gowns after completing rapid antigen tests, a procedure with the ability to have created sprays of oral secretions, increased risk of spread of the home's current COVID-19 outbreak.

Sources: Observations of additional precaution practices in the home; Review of resident health records, the IPAC Standard for Long-Term Care Homes (April 2022), the home's Personal Protective Equipment Policy, and the Provincial Infectious Diseases Advisory Committee's (PIDAC) guideline on Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition (November, 2012); and Interviews with the IPAC Lead, and other staff. [721442]

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WRITTEN NOTIFICATION: CMOH AND MOH

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that Directives #3 and #5 issued by the Chief Medical Officer of Health under the *Health Protection and Promotion Act* were followed in the home regarding isolation of the roommates of COVID-19 symptomatic residents and the appropriate wearing of Personal Protective Equipment (PPE) in rooms of suspected, probable, or confirmed cases of COVID-19.

Rationale and Summary

1. The COVID-19 Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, stated roommates of a COVID-19 symptomatic resident must be placed in isolation under the appropriate additional precautions.

   On a specific date, resident #004 developed COVID-19 like-symptoms, and was isolated with additional precautions at that time. Resident #005, who was resident #004's roommate, was not isolated when resident #004 was isolated and was allowed to leave the room. Resident #004 tested positive for COVID-19 four days after they developed symptoms. The IPAC Lead stated the home had not attempted to isolate resident #005 because they assumed the resident would not be compliant with the isolation. No other precautions were put in place to prevent the potential spread of infection when resident #005 was not isolated while sharing a room with resident #004 who had COVID-19 like-symptoms.

   Resident #006 developed COVID-19 like-symptoms and was isolated at that time. Resident #007, who was resident #006's roommate, was not isolated when resident #006 developed symptoms. It was observed that resident #007 went to the dining room for a meal service with multiple other residents on the same day that resident #006 developed symptoms, and the home was declared to have been in outbreak late that same day.

   Not having followed Directive #3 and isolating the roommates of two COVID-19 symptomatic residents created risk of further spread of the home's COVID-19 outbreak.

2. The COVID-19 Directive #5 for Public Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes, effective December 22, 2021, stated that, at a minimum, all health care workers who provided care to or interacted with a suspected, probable, or confirmed case of COVID-19 were required to wear droplet/contact additional precautions PPE, including gloves, face shields or goggles, gowns, and a well-fitted surgical/procedure mask. As an additional precaution, Directive #5 stated that an N95 respirator be worn by health care workers providing direct care to a suspected, probable, or confirmed case of COVID-19.

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A resident was placed on additional precautions for COVID-19 like-symptoms requiring specific PPE. A staff member entered the resident's room twice without wearing the required PPE. The staff member stated they knew they were required to wear the additional PPE, but they had forgotten to do so.

A resident was placed on additional precautions for COVID-19 like-symptoms requiring specific PPE. A staff member entered the resident's room without wearing the required PPE. The staff member stated they knew they were required to wear the additional PPE but had chosen not to because they would be in and out of the room quickly.

A staff member had not worn an N95 respirator while assisting a resident with a known active COVID-19 infection with a meal. The IPAC Lead stated the staff were expected to wear N95 respirators when in a room with a COVID-19 positive resident.

Not having followed Directive #5 and wearing the proper PPE when providing direct care or interacting with suspected, probable, or confirmed cases of COVID-19 placed residents, staff, and visitors at an increased risk of the spread of the home's current COVID-19 outbreak.

Sources: Observations of PPE practices in the home; Review of resident health records, and MOH Directives #3 and #5; and interviews with the IPAC Lead, and other staff. [721442]

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COMPLIANCE ORDER #001: TRANSFERRING AND POSITIONING TECHNIQUES

NC#004 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 s. 36

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10 s. 36

The licensee shall:

a) Update the home's mechanical lift procedure to include the positions, relative to the resident, of both persons assisting with all mechanical lifts. Changes to the mechanical lift procedure are to be communicated to all staff, and a record of the communication must be kept.
b) Re-train a specific staff member involved with the incident on safe transferring techniques when transferring a resident with a mechanical lift. A record of the training must be kept, including: the dates of the training, the name of the trainer, and the content of the training. The training must include:
   i) A demonstration component using a mechanical lift,
   ii) The resident-relative positions of both persons assisting with a mechanical lift,
   iii) The correct ways to position all mechanical lift slings on/under the resident,
   iv) The correct ways to attach all mechanical lift slings to the lift, and
   v) How to check for the correct attachment of the sling to all mechanical lifts

Grounds

Non-compliance with: O. Reg. 79/10 s. 36

The licensee has failed to ensure that staff used safe transferring techniques when transferring a resident, resulting in the resident sustaining a fall with significant injuries and subsequent hospitalization.

Rationale and Summary

Two staff members were transferring a resident from their wheelchair to their bed with a mechanical lift. During the transfer, one of the clips of the sling had come unhooked from the lift, causing the resident to fall from the sling to the floor. The resident sustained significant injuries requiring hospitalization. The resident had a subsequent significant decline in their health status upon their return from hospital, and, according to the resident's health records, the fall with injury was a contributing factor to the resident's death a short time later.

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At the time of the incident, one staff member was operating the mechanical lift and a second staff member was the "spotter" person to ensure resident safety. The Arjo Account Executive stated that the second "spotter" person must be positioned next to the resident during the transfer for safety until the resident is positioned over the bed or chair. The staff were unable to position the base of the mechanical lift properly under the bed when the resident fell from the sling to the floor, therefore the resident was not positioned over the bed when they fell. The incident investigation notes, and interviews with both staff members present during the incident confirmed that the second "spotter" person was positioned on the opposite side of the bed than the resident when the resident fell from the lift, and was not able to return to the resident in-time to help prevent the fall.

The staff having not used safe transferring techniques while transferring the resident lead to significant injuries which contributed to the resident's death a short time later.

Sources: Review the resident's health records, Critical Incident System report, and the home's Incident Investigation Notes; and interviews with the Arjo Account Executive #124, and other staff. [721442]

This order must be complied with by July 29, 2022