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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 25, 2024
Inspection Number: 2023-1093-0008
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Medex, Ottawa

Lead Inspector	**Inspector Digital Signature**
Laurie Marshall (742466)	Laurie R Marshall Digitally signed by Laurie R Marshall Date: 2024.01.31 07:04:01 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 7, 8, 11, 12, 20, 21, 2023
The inspection occurred offsite on the following date(s): December 14, 22, 2023

The following intake(s) were inspected:

- Intake: #00097097 - Improper care by registered staff resulted in injury to a resident.
- Intake: #00098266 - Complaint regarding care and services of a resident.

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

Resident Care and Support Services

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 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 has failed to ensure that all staff participate in the protocol to wear face shields while within two metres of a resident when there is risk of exposure during an outbreak. Specifically, the licensee failed to ensure compliance with section 9.1 (h) of the IPAC Standard for Long- Term Care Homes that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

Rationale and Summary
Review of the homes Infection and Prevention Control Manual (January 2023, IC-02-01-01 A2) Appendix 2 indicates that a Point of Care Risk assessment (PCRA)

identifies that when there is a risk of exposure, staff are required to wear a face shield within two metres of a resident.

On December 11, 2023 the entire home was declared on Influenza A outbreak.

Review of the homes nursing report binder for the 2nd floor dated December 11, 2023 indicated that additional precautions were required for all staff on the 2nd floor which included masking/shielding.

On December 12, 2023 Inspector observed a dietary aide staff member walking onto second floor unit from the elevator and navigating their way around multiple residents that were less than two metres away after lunch meal service to collect carts with dirty dishes. Dietary Aide staff was wearing a mask and no face shield.

On December 12, 2023, Inspector observed an RN not wearing a face shield walking from 2nd floor north wing towards elevators to go to nursing station. It was observed that there were multiple residents in hall way post lunch that RN walked around with a distance of less than two metres.

Interview with the RN reported that because they were not going into resident rooms or not going near residents they were not required to wear a face shield.

Interview with the IPAC Lead confirmed that the entire home was on respiratory outbreak and that all staff were required to wear a face shield and mask while in the home on all floors and all spaces that residents resided.

By staff failing to participate in the homes infection and prevention control program, specifically related to the use of face shields, when within less than two metres of a resident increases the risk of disease transmission amongst residents and staff.

Sources: Observations; Infection and Prevention Control Manual (January 2023, IC-02-01-01 A2), nursing report binder, Interview with RN#111 and IPAC Lead #102. [742466].

WRITTEN NOTIFICATION: Compliance with manufacturer's instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that an RPN's use of a medical device for a resident was in accordance with manufacturers' instructions.

Rationale and Summary
Review of Medisystem PEPID regarding procedures on a specific medical device identified specific instructions and recommendations when using the device for a resident.

Review of the device manufacturer instructions identified that the device had a maximum volume potential that should not be exceeded.

Progress notes indicated that the RPN attempted to use the device as recommended in the physician orders for a resident and caused the device to

rupture, injuring the resident. The RPN reported that they had accidently used the wrong part of the device for the ordered procedure.

It was reported by the RN and ADOC that the RPN had used the wrong part of the device for the ordered procedure.

The RPN failed to comply with the manufacturer's instructions regarding maximum volume potential that should not be exceeded resulting in injury to a resident.

Sources: Medisystem PEPID, manufacturer instructions, progress notes; Interviews with RPN, RN and ADOC. [742466].

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