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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 7, 2021	2021_823653_0025	011396-21, 011475-21, 011476-21, 011477-21, 015446-21	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 22-24, 27-29, and October 1, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #011396-21 and Log #015446-21 were related to falls prevention and management;
Log #011475-21 was related to Compliance Order (CO) #001 issued on July 15, 2021, within report #2021_610633_0013, related to the Ontario Regulation (O. Reg.) 79/10, s. 229 (4);
Log #011476-21 was related to CO #002 issued on July 15, 2021, within report #2021_610633_0013, related to O. Reg. 79/10, s. 50 (2);
Log #011477-21 was related to CO #003 issued on July 15, 2021, within report #2021_610633_0013, related to O. Reg. 79/10, s. 36.

During the course of the inspection, the inspector(s) spoke with the residents, a resident's Essential Care Giver (ECG), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Security Officers (SOs), Physiotherapist (PT), Housekeepers (HKs), LTC Consultant, and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, meal services, provision of care, staff to resident interactions, reviewed clinical health records, staffing schedules, compliance binders, staff education and training records, active screening records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2021_610633_0013	653
O.Reg 79/10 s. 36.	CO #003	2021_610633_0013	653
O.Reg 79/10 s. 50. (2)	CO #002	2021_610633_0013	653

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents, related to managing a symptomatic individual as specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been

issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive issued on July 14, 2021, once at least one resident or staff has presented with new signs or symptoms compatible with COVID-19, homes must immediately take the following steps in the event of a symptomatic resident: The resident must be placed in isolation under appropriate droplet and contact precautions, in a single room if possible, medically assessed, and tested for COVID-19 using a lab-based Polymerase Chain Reaction (PCR) test as per the COVID-19: provincial testing requirements update.

A resident exhibited new symptoms compatible with COVID-19, and they were not placed on droplet and contact precautions nor tested for COVID-19.

By not immediately taking the required steps in managing a symptomatic resident as required by Directive #3, there was potential for transmission of infection among staff and other residents.

Sources: Resident’s clinical health records, COVID-19 Directive #3 for LTC Homes issued on July 14, 2021; Interviews with a Registered Nurse (RN), and the LTC Consultant. [s. 5.]

2. The licensee failed to ensure that the home was a safe and secure environment for its residents, related to the implementation of the required operational policies and procedures with respect to visitors, as specified in Directive #3.

The home's visitor policy during COVID-19 indicated that all visitors must practice personal protective disciplines such as hand hygiene, physical distancing, and Personal Protective Equipment (PPE) use.

During the inspector’s observation, it was noted that a resident was on droplet and contact precautions, and the resident’s family member did not adhere to the home’s visitor policy with regards to hand hygiene and PPE use prior to entering the resident's room.

By not adhering to the home’s visitor policy, there was potential for transmission of infection.

Sources: Resident’s clinical health records, COVID-19 Directive #3 for LTCHs issued on

July 14, 2021, Extendicare Home’s Visitor Policy During COVID-19 (Ontario) #CRG-01-ON last updated on July 27, 2021; Interviews with a Safety Officer (SO), LTC Consultant, and the Administrator. [s. 5.]

3. During a lunch meal service, a resident’s Essential Care Giver (ECG) was observed touching the personal items of two other residents in the dining room without performing hand hygiene in-between.

By not adhering to the home’s visitor policy, there was potential for transmission of infection.

Sources: Resident’s clinical health records, COVID-19 Directive #3 for LTCHs issued on July 14, 2021, Extendicare Home’s Visitor Policy During COVID-19 (Ontario) #CRG-01-ON last updated on July 27, 2021; Interviews with the LTC Consultant, and the Administrator. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's plan of care sets out clear directions to staff and others who provided direct care to the resident, as it related to safety checks.

A resident was at risk for falls, and one of the interventions listed in their care plan was for staff to check them every 30 minutes for safety during periods where risk for falls was increased, while their Point of Care (POC) documentation for safety checks was scheduled to be done hourly.

A Personal Support Worker (PSW) and an RN stated that the resident was checked hourly, while another PSW and a Registered Practical Nurse (RPN) stated the resident was checked every 30 minutes.

By not ensuring that clear directions were set out in the resident's plan of care, the staff may not have been doing the required safety checks consistently.

Sources: Resident's care plan, POC documentation, Critical Incident System (CIS) report; Interviews with the PSWs, RPN, and RN. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as it related to the application of falls prevention equipment.

A resident was at risk for falls, and one of the interventions in their care plan was for staff to apply a device when the resident was in bed.

The resident had an unwitnessed fall in their bedroom, and the PSW who found the resident on the floor during their rounds confirmed that the device was not in place at the time of the incident.

By not ensuring the application of the device, staff were not able to respond as quickly to prevent the fall.

Sources: Resident's care plan and progress notes, CIS report; Interviews with the PSWs, RPN, and RN. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as it related to posting of a falls risk symbol.

A resident was at risk for falls, and one of the interventions in their care plan was posting of a symbol that would identify their fall risk. Two separate observations by the inspector showed that the resident did not have the symbol posted on their door.

By not posting the falls risk symbol, staff who did not regularly provide care to the resident may not easily identify the resident’s risk for falls.

Sources: Inspector #653’s observations; Resident’s care plan, CIS report; Interviews with the RPN and RN. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 8th day of October, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.