Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 1, 2021	2021_875501_0024	007849-21, 012583-21, 014863-21	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 Oshawa
82 Park Road North Oshawa ON L1J 4L1

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

SUSAN SEMEREDY (501)

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): November 15, 16, 17, 18, 19, 2021.

The following intakes were inspected in this critical incident inspection:
Log #014863-21 related to the prevention of falls;
Log #012583-21 related to the prevention of falls; and,
Log #007849-21 related to the prevention of falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead/ADOC, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), students and residents.

During the course of the inspection, the inspector observed resident and staff interactions and IPAC practices. The inspector reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

Inspector #732787 was present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

The following concerns were identified in the home related to IPAC:

Precaution signage:
• Two rooms had personal protective equipment (PPE) caddies on their door with no visible precaution signage. According to an RN, residents in these rooms were on contact precautions.
• Two other rooms had PPE caddies on their doors with no precaution signage. According to an RN, one resident was under contact and droplet precautions and the other resident was under contact precautions.

Putting on and taking off of PPE:
• An RPN was in a room with contact precautions with their gown untied at the neck and waist. While providing care the gown was falling off their shoulders and down their arms. As well, the RPN wiped the vital machine before changing their gloves.
• On the same day a PSW admitted they entered a room without applying a eye protection even though they knew the residents were under contact and droplet precautions. As well, there was no garbage disposable for used PPE and the PSW doffed their gown and gloves in an open small waste container inside the room.
• Another PSW was noted to be in another room with contact and droplet precautions without wearing any eye protection.
• A student PSW was inside a room with contact and droplet precautions without gloves, gown and eye protection and within two metres of one of the residents.

Hand hygiene within the dining room:
• Two residents who entered the dining room during lunch were not provided assistance with hand hygiene.
• On another day in the same dining room a PSW was observed taking dirty dishes from a resident and then, without sanitizing their hands, served a resident an entrée from the servery.

During an interview with the IPAC Lead, they indicated that signage is to be placed on the resident room door indicating the type of precautions necessary. As well, proper application of gowns includes tying the gown at the waist and neck and when cleaning equipment, gloves should first be taken off. The IPAC Lead stated that proper garbage bins for disposal of PPE should be made available and all those entering a room with contact and droplet precautions need to be wearing a gown, gloves, mask, and eye protection. In addition, staff should assist residents when they enter the dining room with

hand hygiene.

Failing to ensure staff participated in the implementation of the home's IPAC program increased the risk of transmission of infections.

Sources: Observations and interviews with the IPAC Lead and other staff members. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were implemented to respond to these behaviours.

A resident had a fall and sustained an injury. According to progress notes and interviews with staff, the resident had been demonstrating responsive behaviours for most of the shift. According to the medication administration record, the resident had an order for an as needed medication for responsive behaviours. Documentation indicated this medication was not given. Two PSWs stated they had reported to an RPN that the resident was demonstrating responsive behaviours many times throughout the shift. The RPN indicated they did not know why they had not considered giving the resident medication but confirmed that as needed medication in such cases should be considered. An interview with the DOC verified the resident should have been given medication to respond to this situation.

Failing to implement strategies to address responsive behaviours put the resident and others at actual risk for harm.

Sources: The resident's clinical record and interviews with the DOC and other staff members. [s. 53. (4) (b)]

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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) 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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that reports made to the Director included the names of any staff members who were present at or discovered the incident.

Two Critical Incident System (CIS) reports submitted to the Director did not include the staff members who were present at or discovered the incidents. An interview with an ADOC confirmed these reports did not include the above-mentioned information.

Sources: CIS reports and an interview with the ADOC. [s. 107. (4) 2. ii.]

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 reports made to the Director include names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

Issued on this 6th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2021_875501_0024
Log No. / No de registre :	007849-21, 012583-21, 014863-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 1, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Oshawa 82 Park Road North, Oshawa, ON, L1J-4L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jessica Laurie

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices, specifically putting on and taking off of personal protective equipment (PPE) and to ensure that appropriate precaution signage is posted for those residents on isolation.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures, specifically hand hygiene during meal service and putting on and taking off of PPE.

3. Keep a documented record of the training provided to staff regarding IPAC practices.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

The following concerns were identified in the home related to IPAC:

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During an interview with the IPAC Lead, they indicated that signage is to be placed on the resident room door indicating the type of precautions necessary. As well, proper application of gowns includes tying the gown at the waist and neck and when cleaning equipment, gloves should first be taken off. The IPAC Lead stated that proper garbage bins for disposal of PPE should be made available and all those entering a room with contact and droplet precautions need to be wearing a gown, gloves, mask, and eye protection. In addition, staff should assist residents when they enter the dining room with hand hygiene.

Failing to ensure staff participated in the implementation of the home's IPAC program increased the risk of transmission of infections.

Sources: Observations and interviews with the IPAC Lead and other staff members.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents because the home was not in outbreak but there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was a pattern as the IPAC related concerns were identified in two out of three floors in the home.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O.Reg. 229 (4) and a Compliance Order (CO) was issued on June 22, 2021 and a Voluntary Plan of Correction (VPC) was issued on October 20, 2020.

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Central East Service Area Office