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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5

Original Public Report

Report Issue Date: January 19, 2024	
Inspection Number: 2023-1049-0005	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Scarborough, Scarborough	
Lead Inspector Susan Semeredy (501)	**Inspector Digital Signature** Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2024.01.22 12:08:12 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4, 5, 8-12, 2024

The following intakes were inspected in this complaint inspection:

- Intake: #00100318 - Complaint regarding short staffing and improper care resulting in injury
- Intake: #00102727 - Complaint regarding short staffing, nursing and personal support services and communication methods

The following intakes were inspected in this critical incident (CI) inspection:

- Intake: #00098931 – CI #2117-000011-23 - Respiratory (Parainfluenza) outbreak declared on October 6, 2023 and finalized October 16, 2023
- Intake: #00102046 – CI #2117-000012-23 - Coronavirus disease 2019 (COVID-19) outbreak declared November 17, 2023 and finalized November 27, 2023

- Intake: #00105310 – CI #2117-000013-23 - Respiratory syncytial virus (RSV) outbreak declared on December 29, 2023 and ongoing

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

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards

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)
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 point-of-care signage was in place in accordance with the “Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022” (IPAC Standard). Specifically, a sign that indicated enhanced IPAC control measures were in place was not on a resident’s door according to additional precautions 9.1 (e) under the IPAC standard.

Rationale and Summary
A resident room did not have a sign to indicate what enhanced IPAC control measures were in place. There was, however, donning and doffing signs on the door, as well as an IPAC caddy outside the room with supplies. According to a Personal Support Worker (PSW), they were aware the residents were on precautions and indicated the sign for this had fallen and was somewhere in the room. The PSW donned the appropriate personal protective equipment (PPE), entered the room, and replaced the sign at the door.

The IPAC Manager confirmed signage to signal the additional precautions necessary should have been clearly visible on the door of the resident's room.

Sources: Observation and interviews with a PSW and the IPAC Manager. [501]

Date Remedy Implemented: January 8, 2024

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm was immediately reported to the Director.

Rationale and Summary
A resident had a fall and sustained an injury. During the home's investigation, it became evident that a PSW improperly provided care for the resident. The DOC confirmed they failed to report their suspicion and the information upon which it was based to the Director.

Sources: A resident's progress notes, the home's investigation notes and an interview with the DOC. [501]

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary
It was reported that a resident fell during a transfer and was diagnosed to have an injury. A PSW was found to have used a transfer device improperly. The DOC confirmed that this action did not align with their safe lifting policy.

Failing to use safe lifting techniques risked injuring the resident.

Sources: A resident's progress notes, the home's investigation notes, and interviews with a PSW and the DOC. [501]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a staff member participated in the implementation of the IPAC program.

Rationale and Summary
A staff member entered a resident room that had signage for additional precautions without donning any PPE. The staff member stated they did not realize the room was under additional precautions, as they had failed to notice the sign on the door. The IPAC Manager confirmed all staff entering a resident room with additional precautions should wear the required PPE.

Failing to participate in the IPAC program risked the transmission of infectious disease.

Sources: An observation and interviews with the staff member and IPAC

Manager. [501]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift the symptoms of a resident were recorded.

Rationale and Summary
Progress notes for a resident indicated they began having infectious disease symptoms and was put on room isolation. There were no progress notes for every shift for the next few days. A Registered Practical Nurse (RPN) indicated they worked most of those shifts and even though they were monitoring the resident, they failed to document anything in the progress notes or assessment section of Point Click Care (PCC). The IPAC Manager confirmed that symptoms of the resident were not recorded every shift in PCC as was the home's expectation.

Failing to document infectious disease symptoms put the resident at risk for deterioration in their condition.

Sources: A resident's progress notes and assessments and interviews with an RPN and the IPAC Manager. [501]

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. Re-educate two PSWs on the proper application of PPE including the proper sequence as well as the inappropriateness of applying alcohol-based hand rub (ABHR) to gloves.
2. Conduct visual audits twice weekly for the correct application of PPE by these two PSWs for a period of four weeks. Maintain a record of all audits completed, including the staff completing the audit, dates and times audits were completed, and any corrective action taken, if necessary.
3. Maintain a record of all education provided, including the content covered, date, signature of the PSWs and the person providing the education.

Grounds
The licensee has failed to ensure that staff used appropriate personal protective equipment (PPE) in accordance with the “Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022” (IPAC Standard). Specifically, staff did not donn in the proper sequence the required Personal Protective Equipment (PPE) according to additional precautions 9.1 (f) under the IPAC standard which

includes the appropriate selection application, removal, and disposal of PPE.

Rationale and Summary

(i) A PSW entered a room with additional precautions. There were two residents residing the room. When putting on PPE, the PSW used ABHR to sanitize their hands and then put on a gown. The PSW then put on gloves and changed their surgical mask to an N95 mask, put on a faceshield and then used ABHR to apply on their gloves. An interview with the IPAC manager acknowledged that this was not the proper sequence to apply PPE and using ABHR on gloves was not recommended.

(ii) On a different day another PSW entered the same room with additional precautions. The PSW put on gloves, then a gown and then put ABHR on their gloves. They then applied a faceshield. The PSW admitted they should not have put gloves on first and the IPAC Manager acknowledged using ABHR on gloves was not recommended.

Failing to properly apply PPE risked transmitting infectious disease.

Sources: Observations and interviews with the IPAC Manager and other staff.

This order must be complied with by March 1, 2024

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5

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.