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

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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
Apr 20, 2022	2022_946111_0005	019661-21, 021221-21, 001934-22, 001954-22	Follow up

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 22 to 25, 28, March 1 to 4, 2022.

The following inspections were completed concurrently during this inspection:
-Follow up related to IPAC.
-Critical incident (CI) related to a disease outbreak.
-Two Complaints related to IPAC, housekeeping and supplies.

Additional non-compliance was identified related to the complaint related to medication incidents and was identified under complaint inspection # 2022_946111_0006.

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of care (acting DOC), Assistant Director of Care (ADOC), housekeeping, Environmental Services Manager (ESM), Maintenance staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers, Office manager, Admission Coordinator, Regional Director, Pubic Health Inspector and residents.

During the course of the inspection, the inspector (S): toured the home, observed meal services and supplies, reviewed resident health records, surveillance of infection records, Public Health line listing, maintenance logs, and reviewed the following policies: IPAC, maintenance and housekeeping schedules and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control
Medication
Safe and Secure Home

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

- **7 WN(s)**
- **6 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_875501_0024	111

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 :

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Directive #3 indicated under the COVID-19 guidance document for long-term care homes in Ontario, homes must ensure that physical distancing (a minimum of two metres or six feet) is practised by all individuals at all times, between residents, and a home's policies must set out that residents must be encouraged to wear, or be assisted to wear, a medical mask or non-medical mask when in common areas with other residents (with the exception of meal times), as tolerated. On two separate dates, a large number of residents were observed in two separate lounges not physically distanced (sitting less than a foot apart, and residents were not wearing any masks. The registered staff made no attempt to ensure physically distancing of the residents or assisted with donning a mask. The ADOC (IPAC lead) reminded the registered staff to ensure the residents were physically distanced and/or assisted with masks while in common areas. The IPAC Hub Assessment report also identified residents in lounges, hallways and out of rooms were to be assisted with adhering to mask policy. Failing to follow the Directive can lead to the spread of infection in the home between residents.

Sources: observations, IPAC Hub Assessment and interview of staff.

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. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

The licensee has failed to ensure that the Infection Prevention and Control program include daily monitoring of infection in residents.

The home was declared in an outbreak by Public Health (PH). Staff were to monitor for signs and symptoms of infection daily on their daily surveillance form, inform the Infection Control Professional (ICP) of any newly identified infections with residents and the ICP was to report infections to PH and the Ministry of Long Term Care (MLTC). A line listing at the onset of a suspected outbreak was to be completed for residents and staff displaying signs and symptoms of infection and was to include the residents room number.

During the outbreak, the home's previous DOC was the IPAC lead and was no longer in the home. The ADOC indicated they had called PH on a specified date, due to staff demonstrating symptoms of infection and later confirmed with a specified disease. The ADOC confirmed one area of the home was declared in an outbreak by PH, a number of days later. The ADOC confirmed they were unable to locate the daily surveillance records for the specified area during that period of time. The Public Health Inspector (PHI) indicated they had difficulty trying to determine when and where the outbreak had started as the line listing the home had provided, had several incorrect details. The PHI indicated they declared the home in a disease outbreak a number of days later, due to the number of staff affected.

There were no daily surveillance of infection records available for the specified area of the home, where the residents were symptomatic. The PH line listing for staff indicated several staff had tested positive for the disease outbreak, a number of days before PH was informed of a suspected outbreak. The line listings for residents was incorrect and inconsistent. Failing to ensure that the home's outbreak management policy was complied, specifically daily surveillance of infections and line listing of infections, resulted in further transmission of infections and possible spread of a disease outbreak to staff and residents.

Sources: CI, health records of a number of residents Daily Symptom Surveillance Form, Outbreak Line Listing policy, Reporting Infections policy, Infection Surveillance Policy, Public Health line listing and interview of staff and Public Health.

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 Infection Prevention and Control program include daily monitoring of infection in residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including resident bedrooms.

The (acting) Environmental Services Manager indicated that all housekeeping staff were to be cleaning high touch surfaces in resident rooms first, then clean the bathrooms as per the home's policy, and were to use the same specified disinfectant on all high contact surfaces. Two housekeeping staff were observed in different areas of the home not following the homes cleaning procedures in resident rooms. The housekeepers were interviewed and did not know the home's cleaning procedures, for cleaning of high touch surfaces in the resident's rooms or which disinfectant to use. Failing to clean high touch surfaces as per the home's procedures can lead to further contaminated surfaces and spread of infections.

Sources: observations, review of resident room/washroom cleaning policy and interview of staff.

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 procedures were developed and implemented for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The licensee has failed to ensure that as part of the organized program of maintenance services, the licensee ensured that, maintenance services in the home were available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems were maintained in good repair.

During an observation of the home, the Inspector noted a resident room that was not in use. A housekeeper indicated the room was not in use due to maintenance concerns for a number of months. Maintenance staff and the Environmental Services Manager (ESM) both confirmed they just started working in the home and only worked two days a week. Failing to ensure there was adequate maintenance in the home resulted in a resident room not being available for use for an extended period of time and may lead to other maintenance issues in the home not being repaired in a timely manner.

Sources: observations, review of maintenance logs and interview of staff.

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 as part of the organized program of maintenance services, the licensee ensured that, maintenance services in the home were available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems were maintained in good repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (2) Every licensee shall ensure that all the beds that are allowed under the licence are occupied or are available for occupation. 2007, c. 8, s. 104. (2).

Findings/Faits saillants :

The licensee has failed to ensure that all the beds that are allowed under the license are occupied or are available for occupation.

During the inspection, the Inspector observed a number of resident rooms being used for storage and unable to be occupied. One of the resident rooms had not been in use for a number of months due to maintenance repairs required. The ADOC and the Admissions Coordinator both confirmed the specified resident rooms had not been occupied for a period of greater than a year. The Administrator indicated the beds had not been used due to fire door concerns and was unable to provide any documented evidence from the local fire department. A Central East LHIN (CELHIN) document indicated the identified rooms were vacant due to issues in physical layout of the home. The Extendicare Regional Director confirmed all of the identified beds had not been placed in abeyance and indicated all of the rooms would be cleared of storage and/or furniture and placed back in use immediately. For a period of greater than a year, a number of resident beds had not been occupied or available for occupation.

Sources: observations, review of admissions, and interview of staff.

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 all the beds that are allowed under the license are occupied or are available for occupation, to be implemented voluntarily.

WN #6: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

The licensee has failed to ensure that staff monitor and record symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and take immediate action as required.

The home was declared in a disease outbreak by Public Health (PH) for a specified period and there were a number of confirmed resident cases, and included hospitalization and death. The ADOC indicated they had contacted PH and directed to place all the residents on a specified unit on isolation and tested. There were no daily surveillance of infections records available for review for the specified unit and the PH line listing for residents on the specified unit identified resident #005 and #006 as asymptomatic. Resident #005 had no documentation to indicate when the resident was placed on isolation and no indication the resident was monitored every shift for symptoms. Resident #006 began having symptoms of infection, was sent to hospital and later returned to the home on palliation. The resident was not monitored, or symptoms documented on every shift and there was no indication when the resident was placed on isolation. Failing to ensure that residents are monitored for symptoms of infection and are recorded on every shift in accordance with evidence-based practices, may result if infections going undetected and immediate actions taken as required.

Sources: CI, health records of resident #005, #006 and #007, Daily Symptom Surveillance Form, Public Health line listing and interview of staff.

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 staff monitor and record symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and take immediate action as required., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Inspector noted that a resident room was not in use and was being used for storage. A housekeeper indicated the resident room was not in use due to maintenance concerns and was unaware how long the room had remained out of use. The Administrator indicated the resident room had not been used for admission for a number of months due to bathroom disrepair. The maintenance staff confirmed that staff were to record any maintenance concerns in the electronic maintenance log book and when the work was completed, it would be recorded in the same log. The maintenance staff confirmed they had recently been given access to the electronic maintenance log book and was not aware of any maintenance concerns for the specified resident room. The maintenance logs indicated a number of months prior, there was a maintenance request to repair a toilet in the specified resident room but no indication when the repairs had been completed. The Office Manager confirmed the resident room had remained out of use for a number of months due to maintenance issues. The ESM confirmed the maintenance repairs to the specified resident room were now completed. Failing to ensure the home and equipment was maintained in a safe condition and in a good state of repair, resulted in two residents beds not being accessed for a number of months.

Sources: observations of resident room, maintenance log book and interview of staff.

Issued on this 26th day of April, 2022

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

Original report signed by the inspector.