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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022_1071_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare Oshawa

Lead Inspector
Diane Brown #110

Inspector Digital Signature
Diane Brown
Digitally signed by Diane Brown
DN: c=ca, st=on, o=Government of Ontario, ou=People, serialNumber=DSAP151069, cn=Diane Brown
Date: 2022.09.30 11:36:51 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 20, 21, 22, 26-29, August 3-5, 8-12, 15, 2022.

The following intake(s) were inspected:
Log #009805-22 - related to unsafe transferring of residents
Log #001301-22 - related to staff to resident abuse
Log #007358-22 - related to infection prevention and control and COVID-19 disease outbreak
Log #013759-21 - related to infection prevention and control and COVID-19 disease outbreak
Log #001917-22 - related to lack of bathing and staff to resident neglect
Log #008426-22- related to a Follow-up to compliance order (CO) #001 from inspection #2022_94611_0006.
Log #009233-22 - related to resident care and improper medication administration.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 135 (1)	2022_94611_0006	001	Diane Brown (110)

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION COOLING REQUIRMENTS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 23. (4)(a)(b)

The licensee failed to ensure the heat related illness prevention and management plan for the home was implemented during the period from May 15 to September 15 when the outside temperature forecasted by Environment and Climate Change Canada for the area was 26 degrees Celsius or above at any point during the day and when the temperature in an area in the home measured by the licensee in reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary

On July 20, 2022, Environment Canada forecasted the Oshawa area to be 26.2 degree C at 0900hrs and 29.3 degrees C between 1400-1500hrs.

The Administrator confirmed there were some resident rooms not serviced by air-conditioning in the home. At 1532hrs residents #011 and #012 expressed they were feeling hot. The home's AlertLab temperature monitoring system revealed the temperature was 26 degree C in their room at this time. Two other rooms were also identified by AlertLab to be at 26 degree C at 1458hrs and 1505hrs respectively.

A tour of the home revealed the blinds had not been pulled, residents were not offered to be taken to cooling areas or offered more drinks. The administrator confirmed the heat related illness prevention and management plan had not been initiated on July 20, 2022.

The licensee failed to ensure the home's heat related illness prevention and management plan for the home was implemented placing residents at risk of heat related illness.

Sources: Tour of home. Interview with residents. Review of the home's temperature monitoring records. Extendicare policy entitled 'Preventing Heat-Related Illnesses RC-08-01-04 and interview with Administrator.

Written Notification Infection Prevention and Control Inspection

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (2)(b)

The licensee failed to ensure the infection prevention and control program (IPAC) required under the Act complied with the requirements of the IPAC standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

The licensee failed to ensure the IPAC standard issued by the Director was followed as it related to environmental controls, including location/placement of residents' equipment.

On July 20, 2022, the Inspector and administrator jointly conducted air temperature monitoring and resident interviews. At 1440hrs the door of a semi-private room was open to the hallway with two residents observed inside. A precaution sign was posted on the door as one resident, #014, was symptomatic for a respiratory infection. Inside the room a piece of equipment was observed on and positioned in resident #014's room area facing the resident's end of the bed.

The administrator confirmed equipment was not to be used for any residents with respiratory infections and was removed.

The licensee failed to ensure the requirements of the IPAC standard were met when an identified piece of equipment was used for cooling in a shared room and one resident was symptomatic for a respiratory infection.

Sources: IPAC Standard 9.1. Observations. Interview with the administrator.

The licensee failed to ensure the infection prevention and control standard issued by the Director was followed as it related to ensuring that residents received hand hygiene prior to meals.

An observation of a lunch meal service revealed resident's entering or being escorted into the dining room and not receiving hand hygiene (HH). Personal Support staff stated usually there was a designated staff at the entrance of the dining room to provide HH to residents prior to their entry. The IPAC lead acknowledged that residents were to be provided with HH prior to entering the dining room.

Failure to provide hand hygiene to residents may result in the further spread of infectious diseases.

Sources: Observations on July 20, 2022, 3rd floor; Interviews with PSW staff and IPAC Lead.

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 102 (1)]

The licensee failed to ensure that the infection prevention and control program including an outbreak management system for detecting, managing, and controlling infectious disease outbreaks and reporting protocols based on requirements under the *Health Protection and Promotion Act* were met.

Rationale and Summary

The Ministry of Long-Term Care received a complaint regarding the ongoing pattern of outbreaks in the home.

The home's last COVID-19 outbreak was declared on May 26, 2022. On May 21, 2022, the home met the Regional Municipality of Durham's case definition of a confirmed outbreak. On May 21, 2022, the Regional Municipality of Durham's case definition requiring single case reporting of a resident for a suspected COVID-19 outbreak was also met requiring the home to report as soon as possible and within one business day. The home did not report to the Regional Municipality of Durham's public health until May 26, 2022 and did not meet the reporting requirements.

The IPAC lead acknowledged, having looked back, the case definition and requirement for reporting was not met on May 21, 2022 as Public Health was not notified until May 26, 2022 at which time an outbreak was declared.

Failure to report within the required time frame to public health may compromise the outbreak management of a high risk setting.

Sources: Complaint Log #007358-22. The Regional Municipality of Durham April 20, 2022 correspondence: New guidance Management of Cases and Contacts of COVID-19 in Ontario. Interview with IPAC lead. Public Health Inspector #101.

WRITTEN NOTIFICATION BATHING

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 33

The licensee failed to ensure that resident #007 was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary

The Ministry of Long-Term Care received a complaint that resident #007 was not provided showering as their preferred bathing choice.

The resident's plan of care identified their bathing preference as a shower. The resident enjoyed their showers according to the resident's substitute decision maker (SDM). A review of the bathing documentation confirmed that resident #007's was infrequently showered, with two showers identified in one month.

Staff interviews confirmed the resident was not showered at a minimum of twice a week.

Failure to provide the resident with two showers a week denied the resident a quality-of-life activity and could possibly have impacted their resident personal hygiene.

Sources: Plan of Care, interview with resident's substitute decision maker, bathing documentation in Point of Care (POC). Interviews with PSWs #121, #123, #124, #125, #126 and RPN #122.

WRITTEN NOTIFICATION SAFE AND SECURE HOME

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 5

The Licensee failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

A complaint was received at the MLTC reporting the failure of the home to follow proper isolation practices and COVID-19 testing when a resident was readmitted from the hospital.

The Chief Medical Officer of Health (CMOH) Directive #3, set 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, the LTCH was required to have in place the following:

- Policies and procedures with respect to admissions and transfer.
- Rooms identified and set aside for isolation purposes. Individuals requiring isolation must be placed in a single room on Droplet and Contact Precautions.
- Immediate self-isolation of residents with one or more of the most common symptoms, including cough, of COVID-19.

Extendicare's admission and transfer policy directed the readmission of a fully immunized resident to have a lab-based PCR test with results prior to the time of arrival. The resident must be placed in isolation on droplet/contact precautions if the test is pending. If test is positive, then isolation and droplet/contact precautions must continue.

Resident #001 returned to the LTCH and the home failed to ensure COVID-19 testing upon return and proper isolation in keeping with CMOH Directive #3 and Extendicare's admission and transfer policy.

Sources: The Chief Medical Officer of Health (CMOH) Directive #3, implementation date of July 16, 2021. Extendicare policy entitled 'Resident Admission/Transfer Algorithm', dated August 5, 2021,

Failure to following Directive #3 could have impacted other residents when resident #001, who was symptomatic and an unknown COVID-19 exposure risk while in hospital was not placed in a single room, not tested for COVID-19 prior to or upon admission from hospital and not maintained in isolation until a negative COVID-19 test was received.

WRITTEN NOTIFICATION [LEGISLATIVE SECTION TITLE]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee failed to ensure that a Minister's operational policy directive was followed.

Rationale and Summary

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a. The Minister's Directive required LTCH's to ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

A record review of three residents, #003, #004 and #005 along with staff interviews confirmed that registered staff were not taking and recording the resident temperatures at least once a day.

Failure to assess resident temperatures daily may prevent early identification, treatment and containment of the COVID-19 virus.

Sources: The Minister's Directive: COVID-19 response measures for long-term care homes dated May 3, 2022. Point Click Care (PCC) temperature summaries and staff interviews.

b. The Minister's Directive required LTCH's to ensure that the COVID-19 asymptomatic screen-testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care homes were followed.

Screener #100 swabbed Inspector's nasal cavity and placed the swabbed COVID-19 rapid test in the solution for less than one minute. The screener stated that they would leave the swab in the solution for one minute 40 seconds but confirmed they did not time it. The manufacturer's instructions require the swab to be in the solution for at least two minutes. The Infection Prevention and Control Lead confirmed the requirement to follow the manufacturer instructions.

Failure to follow the instructions related to COVID-19 testing may result in false testing outcomes.

Sources: The Minister's Directive: COVID-19 response measures for long-term care homes dated May 3, 2022. Observations. Interview with PSW #100, administrator and IPAC lead.

WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 140 (1)

The licensee failed to ensure that a medication administered to resident #010 had been prescribed for them.

Rationale and Summary

A complaint was received by the MLTC that medication was being administered without a physician's order.

Resident #010 returned to the home from hospital, where a resident's medication had been discontinued. A review of the medication administration record (MARS) revealed that the

identified medication was administered May 7, 8, 9, 10, 11 and 12, 2022, to the resident without an Order.

The failure to ensure the medication was ordered prior to being administered could have negatively impacted the resident's health status.

Sources: Resident #010's health record and Lakeridge Health resident discharge documents. Medication Administration Records and interviews with RN #110 and DOC.

WRITTEN NOTIFICATION PLAN OF CARE

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (2)

The licensee failed to ensure that the care set out in the plan of care for resident #010 was based on their needs and preferences.

Rationale and Summary

Resident #010 had their prescribed medication, increased with no assessment to support the need for an increase. An interview with the DOC confirmed that prior to the increase staff were expected to initiate an assessment from behavioral supports (BSO) and/or complete a pain assessment. The DOC confirmed there was no assessment prior to the increase in the resident's increase in medication as was required.

The licensee failed to ensure resident #010's needs were assessed prior to increasing the identified medication.

Sources: Resident #010's health record, interviews with RN #129, RN #110, DOC

WRITTEN NOTIFICATION PLAN OF CARE

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (5)

The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A complaint was received by the MLTC that medication was being increased without the resident's substitute decision-maker's (SDM) consent.

Resident #010's medication was increased without the SDM's consent. An interview with the SDM revealed they had not provided consent for the documented increased dosage and were upset to see the sedated state of their mother when they visited.

Three months later resident #010's medication was again increased without the SDM's consent.

Interviews with registered staff and the DOC confirmed that consent was required prior to a resident's medication changing. A record review confirmed the lack of consent related to both increases of medication.

The resident's substitute decision-maker was not given an opportunity to participate fully in the development and implementation of the resident's plan of care when the resident's medication was increased without consent.

Sources: Resident #010's health record, MARS medication administration records and. Interviews with RPN #130, RN #129, RN #110 and DOC.

WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEM

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 123. (3)

The licensee failed to ensure that the homes' medication management policies were implemented.

Rationale and Summary

Staff did not comply with completing a 'Best Possible Medication History' form required in the licensee's medication reconciliation policy when a resident returns to the home from hospital.

Resident #010 returned to the home from a hospital admission. Registered staff did not complete a medication reconciliation, comparing the most recent medication administration record again the hospital Physician's orders.

One of resident #010's medication was discontinued during their hospital stay. The medication was readministered upon return to the home as a medication reconciliation had not been completed to identify that the medication had been discontinued. The medication continued to be administered until a concern had been brought forward.

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Failure to complete the medication reconciliation form and process as outlined in the home's policy could place the resident at risk of adverse drug events when the medication was readministered when discontinued.

Sources: Extendicare's Medication Reconciliation policy RC-16-01-11 dated January 2022. Resident health record; medication administration records (MARS) and Lakeridge Health resident discharge documents. Interviews with RPN #126, #127, #128, #130, RN #110 and DOC.