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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 22, 2024
Inspection Number: 2024-1071-0005
Inspection Type: Proactive Compliance Inspection
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Oshawa, Oshawa

Lead Inspector	**Inspector Digital Signature**
	Julie Dunn Digitally signed by Julie Dunn Date: 2024.10.23 11:36:41 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7 - 11 and 15 - 16, 2024.

The following intake(s) were inspected:

- Intake: #00128304 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that a staff member received annual retraining in infection prevention and control.

Rationale and Summary
During a proactive compliance inspection, staff training records for infection prevention and control (IPAC) were reviewed.

The IPAC training records for a staff member showed that it had been more than four years since the staff member completed the required IPAC training.

The Director of Care (DOC) confirmed that the staff member had not completed the IPAC education. The DOC indicated that the staff member took a leave of absence to work elsewhere. The staff member returned to work in the LTC home, and the DOC acknowledged that the staff member should have completed the training at that time.

In failing to ensure that the staff member received the annual IPAC retraining, there was a risk of the staff member not having the most up-to-date IPAC education.

Sources: IPAC training records for staff, interview with DOC.

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked to restrict unsupervised access to those areas by residents.

Rationale and Summary
A Proactive Compliance Inspection was conducted.

During the initial tour of the long term care home and on several occasions throughout the inspection, doors in three home areas were found unlocked when not supervised by staff. In one home area, a door with a sign indicating utility room was observed to be unlocked, with a hopper visible inside. In a second home area, a door with a sign indicating shower room was left unlocked, and observed inside were a shower chair, a shelf stocked with soap, shampoo, a bottle of all-purpose disinfectant, and disinfecting wipes. Another door with a sign indicating utility room was unlocked, inside was observed a large garbage bin, hopper, a mop, and bucket. Similarly, in a third home area, doors with a sign indicating a bathing room and a shower room were found unlocked, observed inside was a tub, soap, shampoo, shaving razor, body wash and disinfectant.

A Registered Practical Nurse (RPN) indicated that the expectation was to keep the doors including the utility room door, shower room door, and bathing room door closed and locked at all times when they were not supervised by staff. They further explained that when the doors were left open, residents were at risk of chemical ingestion and falls.

Environmental Service Manager acknowledged the same. They mentioned that they had contacted and scheduled their third party service to repair the doors, as they were not engaging properly when closed.

Failure of the licensee to ensure doors leading to non-residential areas are kept closed and locked posed a risk of harm to residents.

Sources: Observations, Interviews with staff.

WRITTEN NOTIFICATION: Air Temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
During a Proactive Compliance Inspection, air temperature records were reviewed.

The air temperatures were recorded hourly in 29 different resident areas of the home, including resident rooms on each floor, hallways and common areas. There were several days with air temperatures recorded below 22 degrees Celsius in more than one home area. The air temperature recorded in the corridor of one home area was below 22 degrees Celsius for four full days, at times as low as 19.5 degrees Celsius.

On an afternoon during the inspection, a resident stated they felt cold. The resident

was wearing a fleece sweater/jacket and asked if they could be moved somewhere warmer. A staff member was wearing a hooded sweater over their uniform and indicated that they found it to be cold in the home.

The Environmental Services Manager (ESM) confirmed that the minimum acceptable air temperature in the long-term care home was 22 degrees Celsius and that they received alerts when air temperatures in the home were outside of the acceptable range. The ESM acknowledged that there were some air temperatures below 22 degrees Celsius logged in the home's air temperature records.

Failing to ensure the home was maintained at a minimum temperature of 22 degrees Celsius put residents at risk of discomfort.

Sources: The home's air temperature records, interviews with staff and resident, observations.