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
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 8, 2024
Inspection Number: 2024-1049-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Scarborough, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-12, 16-19, 22-25, 29, 2024
The inspection occurred offsite on the following date(s): July 15, 26, 2024

The following intake(s) were inspected:

- Intake: #00113674 - Follow-up Inspection to Compliance order (CO) #001 related to plan of care
- Intake: #00112758 - Critical Incident (CI) #2117-000007-24 was related to injury within unknown cause
- Intakes: #00114848 - CI #2117-000012-24, Intake: #00119740 - C I #2117-000019-24 and
- Intake: #00121577 - CI #2117-000024-24 were related to alleged abuse
- Intake: #00120438 - CI #2117-000021-24 was related to disease outbreak

The following intake was inspected in this complaint inspection:

- Intake: #00115431 was related to infection prevention and control (IPAC)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order # from Inspection #2024-1049-0001 related to FLTCA, 2021, s. 6 (10) (c)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee has failed to complete a reassessment of the resident's behaviour after an alleged resident to resident abuse.

Rationale and Summary:

The home reported that the resident verbally and emotionally abused another resident.

The home policy titled "Responsive Behaviours," directed staff to conduct an in-depth assessment of the resident's behaviours to determine interventions to prevent and minimize re-occurrence.

The Registered Practical Nurse (RPN) acknowledged it was the responsibility of the registered staff to initiate the Dementia Observation System (DOS) after an incident had occurred with a resident, to identify triggers, interventions, and strategies to address the resident's responsive behaviour(s). The home's Behaviour Support Ontario (BSO) Nurse acknowledged the DOS was not completed for the resident as per policy.

Failure to complete a reassessment of the resident's behaviour increased the risk of potential resident to resident altercations.

Source: Review of residents clinical records; Responsive Behaviours policy, interviews with RPN and BSO Nurse.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 implement any standard or protocol issued by the

Director with respect to infection prevention and control (IPAC).

(i) The staff and essential visitor did not adhere to the measures in accordance with the "IPAC Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, they did not apply the appropriate selection of Personal Protective Equipment (PPE) which was required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary:
(a) Signage on the resident's room door indicated they were on droplet and contact precautions. An essential visitor did not don eye protection upon entering resident's room, who was on additional precautions. The essential visitor applied the face shield immediately after being reminded by Personal Support Worker (PSW).

The IPAC Manager confirmed that the visitor should have worn a face shield when donning PPE.

(b) During an outbreak, a Registered Nurse (RN) was observed in a resident's room who was on additional precautions wearing only a surgical mask with no gown, gloves, or eye protection. RN acknowledged the room they entered required additional precautions and confirmed that they entered without donning the required PPE.

The IPAC Manager acknowledged that when in a resident's room who was on droplet and contract precautions, all staff were expected to wear a mask, eye protection, gloves, and a gown.

Failure to wear the required PPE may result in increased risk of infection transmission in the home.

Sources: Observations; review of IPAC Standards; review of resident's clinical records and interviews with PSW, RN and IPAC Manager.

(ii) The staff did adhere to the measures in accordance with under the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard). Specially, they didn't comply with applicable masking requirements at all times which was required by Personal Protective Equipment (PPE) 6.7 under the IPAC Standard.

Rationale and Summary:
(a) Resident Service Aide (RCA) was seen not wearing a surgical mask on a COVID-19 outbreak home area. They acknowledged they should have been wearing a surgical mask on the outbreak home area.

(b) Registered Practical nurse (RPN) was seen not wearing a surgical mask on a COVID-19 outbreak home area, walking through the dining room during a meal service. They admitted that they should have been worn a surgical mask on the home area during a COVID-19 outbreak.

The IPAC Manager acknowledged that both staff should worn a surgical mask when on the home area in a COVID-19 outbreak.

Failure to adhere to IPAC measures may increase the spread of infection in the home.

Sources: Observations; and interviews with RCA, RPN and IPAC Manager.

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