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

Public Report

Report Issue Date: June 16, 2025
Inspection Number: 2025-1049-0003
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Scarborough, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4-6, 9-13, 16, 2025

The following intake(s) were inspected:

- Intake #00147287/Critical Incident (CI) #2117-000024-25 was related to infection prevention and control
- Intake #00148399/ CI # 2117-000025-25 was related to medication management

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with. In accordance with Additional Requirement 9.1 (f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), two Personal Support Workers (PSW) did not perform hand hygiene when removing the required Personal Protective Equipment (PPE) according to additional precautions which includes the appropriate removal of PPE.

A resident was on droplet contact precautions when a PSW did not perform hand hygiene at the correct increments when removing PPE.

A resident was on contact precautions when a PSW did not perform hand hygiene until all PPE was removed. The IPAC Lead confirmed that the correct sequence for PPE removal was not completed by both PSWs.

Sources: Observations and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 three residents' symptoms were recorded on each shift when they were exhibiting symptoms indicative of respiratory illness while the facility was on outbreak.

The IPAC Lead confirmed that symptoms were not recorded on each shift for the residents.

Sources: Review of residents clinical records, and interview with IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident. Specifically, a resident was administered drugs that were prescribed for another resident. The Registered

Practical Nurse (RPN) and Associate Director of Care (ADOC) confirmed that drugs that were not prescribed for the resident were administered.

Sources: Review of resident clinical records, interview with RPN and ADOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A resident was prescribed medications which were not administered. The RPN and ADOC confirmed that drugs that were prescribed for the resident were not administered.

Sources: Review of resident clinical records and interview with RPN and ADOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. An RPN discovered that they had administered the resident's medication to a co-resident and no records of actions taken for the resident were identified.

Sources: Review of resident's clinical records, interview with RPN and ADOC.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that the written policy related to medication incident and reporting was complied with when immediate action was not taken by an RPN to notify the physician for treatment directions when a medication incident occurred.

In accordance with Section 11 (1)(b) of Ontario Regulation 246/22, where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy the licensee was required to ensure that the policy was complied with.

The Medication Incident and Reporting policy implemented in the home directed staff to take immediate action in the event of an incident/adverse drug event by notifying the physician for treatment directions.

A resident was administered their medications as well as another resident's medications. The RPN waited a couple of hours to inform the Charge Nurse that a medication incident had occurred delaying notification to the physician and transfer to hospital.

Failure to take immediate action following the medication incident placed the resident at risk of adverse health outcomes.

Sources: Review of resident's clinical records and home's policy, interview with RPN.

COMPLIANCE ORDER CO #001 Duty to protect

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Re-educate an RPN and two Registered Nurses (RN) on the home's medication management policies; specifically, responding to medication incidents and reporting protocols
2. Re-educate the RPN on the home's policies and procedures related to medication administration.
3. Present this incident as a case study to all registered staff in the home prior to the compliance due date.

Grounds

The licensee has failed to ensure two residents were not neglected by staff following medication incidents.

In accordance with Ontario Regulation 246/22, s. 7 defines “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

a. A resident was administered their morning medication along with medications intended for a co-resident. The resident had experienced adverse effects. The RPN failed to take action by reporting to the Charge Nurse immediately upon discovery, jeopardizing the health and well-being of the resident. Treatment was delayed by a couple of hours when resident was transferred to hospital for assessment and treatment.

Failure to take immediate action following the medication incident placed the resident at risk of adverse health outcomes.

Sources: Review of resident clinical records, and interview with RPN.

b. An RPN had discovered that they had administered a resident's medication to a co-resident and failed to take action to ensure the resident was administered their prescribed medication.

The RPN reported to two RN(s) who failed to assess and monitor the resident after discovering that a medication incident had occurred. Interview with the ADOC confirmed that registered staff are expected to work together to respond to a medication incident.

Failure to take immediate action following the medication incident placed the resident at risk of adverse health outcomes.

Sources: Review of resident clinical records, interviews with RPN and ADOC.

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Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

This order must be complied with by

July 25, 2025

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

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.