Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Nov 22, 2019	2019_626501_0025	008360-19, 012685-19, 019490-19, 020832-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SEMEREDY (501), ANGIEM KING (644)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 31, November 1, 5, 6, 7, 8, 12, 13, 14, 15, 2019.

This inspection took place concurrently with complaint inspection 2019_807644_0016.

The following intakes related to critical incident system (CIS) reports were inspected:
Log #008360-19 related to the prevention of abuse and neglect
Log #012685-19 related to the prevention of abuse and neglect and responsive behaviours
Log #019490-19 related to the prevention of falls
Log #020832-19 related to the prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Business Manager, physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), recreation aide, residents and substitute decision-makers (SDMs).

During the course of inspection, the inspectors(s) conducted observations of personal care, staff and resident interactions, reviewed health records, home's complaint and investigation records, call bell records, video surveillance footage and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective.

The home submitted a critical incident system (CIS) report related to resident #001 sustaining an injury after falling and subsequently passing away in the hospital.

A review of resident #001's minimal data set (MDS) assessment indicated the resident was at risk and had a history of falls. According to this assessment, the resident would ambulate with an assistive device, self-transfer and ambulate with staff supervision at times. A review of post fall assessments indicated the resident had previous falls.

A review of a post fall assessment for a fall a few months before indicated the resident sustained injuries, was transferred to the hospital and returned a short time later. A review of a post fall screen after this fall indicated the resident was now at high risk. A review the plan of care indicated the only intervention initiated after this fall was the falling star logo.

An interview with RPN #101 indicated that they were in another resident's room when they were alerted that resident #001 was found on the floor related to the last fall. According to RPN #101, they thought resident #001 had an alarm on their assistive device but did not know why it was not part of the written plan of care and did not remember hearing it that day.

An interview with PT #105 indicated they did not know whether resident #001 had an alarm but stated such a device would have been ideal for resident #001 since they were constantly trying to get up. The PT also indicated that someone who tends to get up and be unsteady should be closely supervised or near the nursing station.

An interview with Associate Director of Care (ADOC) who is the lead for the fall prevention program in the home, indicated they did not know whether resident #001 had an alarm or not but confirmed that it was not part of the resident's plan of care.

An interview with the Director of Care (DOC) and ADOC confirmed that there was a gap in the completion of the plan of care for resident #001 and that resident #001 would have benefitted from an alarm. The DOC and ADOC indicated that resident #001's interventions should have included keeping the resident in a more visible area and implementing some type of alarm system.

Resident #001 had a previous fall where they sustained injuries and following this incident the home failed to ensure that the plan of care was reviewed and revised. [s. 6. (10) (c)]

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 resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was protected from abuse by anyone.

The home submitted a critical incident system (CIS) report related to an allegation by resident #002 that personal support worker (PSW) #116 was abusive with them. According to the report, resident #002 reported to a family member that during care a PSW and the resident had an altercation that resulted in altered skin integrity.

A review of the home's investigation notes indicated the home completed their investigation and found evidence that PSW #116 had committed an act of abuse upon resident #002.

A review of a minimal data set (MDS) assessment dated indicated resident #002 required two staff to attend to the resident related to responsive behaviours. According to the plan of care, the resident required extensive assistance with two staff for identified activities of daily living.

An interview with PSW #111 indicated PSW #116 was already providing care to resident #002 on an identified date when PSW #111 came to assist. PSW #111 stated they observed altered skin integrity on the resident later in the day and RPN #108 attended to this. An interview with RPN #108 indicated that at the end of their shift, resident #002's family member came to the nursing station and told them and RPN #113 that a PSW abused the resident causing altered skin integrity. RPN #108 stated they went and observed resident #001 had altered skin integrity and the resident stated PSW #116 had been abusive. An interview with RPN #113 indicated they remembered observing the altered skin integrity on resident #002 and stated the resident told them it was not accidental.

An interview with ADOC #103 and ED #115 confirmed that based on the home's investigation, it was felt the alleged abuse of resident #002 by PSW #116 was founded. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 215. Police record check

Specifically failed to comply with the following:

s. 215. (2) The police record check must be,
(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 451/18, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the police reference check was conducted within six months before the staff member was hired.

A review of recently hired staff members indicated PSW #117 was hired on an identified date. A review of results for police record checks indicated the date of search for PSW #117's check was not conducted within six months.

An interview with ED #115 and ADOC #103 confirmed that this police reference check was not conducted within six months before the staff member was hired. [s. 215. (2) (b)]

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.