Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

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 19, 2022
Inspection Number #2022_1379_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☒ Other IPAC and Cooling Requirements

Licensee
AXR Operating (National) LP

Long-Term Care Home and City
Bay Ridges
900 Sandy Beach Road, Pickering, ON L1W 1Z4

Lead Inspector
Catherine Ochnik (704957)

Additional Inspector(s)
Marian Keith (741757)

Inspector Digital Signature
Catherine Ochnik
Digitally signed by Catherine Ochnik
Date: 2022.09.27 10:27:27 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 30, 31, September 1, 6, 7, 8, 9, 12, 13, and 14, 2022.

The following critical incident intake(s) were inspected:

- Log # 011935-22 (CIS #2895-000016-22) related to staff to resident neglect.
- Log # 011934-22 (CIS #2895-000015-22) related to staff to resident abuse.
- Log # 017925-21 (CIS #2895-000023-21) related to staff to resident abuse.
- Log # 017453-21 (CIS #2895-000022-21) related to staff to resident abuse.

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

- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Safe and Secure Home

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.28 (1) 2

The licensee has failed to ensure that a complaint of 'rough' care toward resident #007 was reported immediately to the Director.

Rationale and Summary
The home was required to submit a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC), which was to be completed by the Director of Care (DOC) using the Critical Incident System (CIS). No report was received via the after-hours Info Line.

A complaint regarding 'rough' care toward resident #007 was reported to the home. A CI was reported not reported to the MLTC immediately. The DOC acknowledged that the home failed to submit the report immediately. The DOC stated that the incident was reported only after the prompt from the home's corporate consultant. No report was received by the MLTC via the after-hours Info Line.

Sources:
CI report and interview with DOC.

[741757]

WRITTEN NOTIFICATION [LEGISLATIVE SECTION TITLE]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.28 (1) 1

The licensee has failed to ensure that a missed a meal for resident #007 on May 6, 2022, was reported immediately to the Director.

Rationale and Summary
The home was required to submit a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC), which was to be completed by the Director of Care (DOC) using the Critical Incident System (CIS). No report was received by the MLTC via the after-hours Info Line.

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On a specified date, resident #007's evening meal was missed. A CI was reported not reported to the MLTC immediately. The DOC acknowledged that the home failed to submit the report immediately. The DOC stated that the incident was reported only after the prompt from the home's corporate consultant. No report was received via the after-hours Info Line.

Sources:
CI report and interview with DOC.

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