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 16, 2023

Inspection Number: 2023-1379-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

Long Term Care Home and City: Bay Ridges, Pickering

Lead Inspector	**Inspector Digital Signature**
Rexel Cacayurin (741749)	Chantal D Lafreniere Digitally signed by Chantal D Lafreniere Date: 2023.10.16 12:56:53 -04'00'

Additional Inspector(s)
Chantal Lafreniere (194)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11-15, 18, 20-22, 25-26, 2023.

The following intake(s) were inspected:

Critical Incident related to an unexpected Death.
Critical Incidents related to staff to resident abuse, resident to resident abuse and neglect of care.
A complaint related to reporting of abuse.
A complaint related to neglect.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for a sets out, clear directions to staff and others who provide direct care to the resident related to continence care.

SUMMARY AND RATIONALE

A complaint and a Critical Incident Report (CI) were submitted to the Director. The CI indicated that a resident had been found by family members requiring continence care.

The plan of care for the resident related to continence at the time of the incident, provided some interventions. The plan of care at the time of the inspection provided further interventions. The resident's written plan of care did not provide clear direction to the staff.

Several Personal Support Workers indicated different routines not identified in the plan of care, related to the resident's continence care.

The Director of Care (DOC) confirmed that the resident was to be provided the assistance for continence as directed in the plan of care.

Review of the current Point of Care (POC) documentation for the resident for several days indicated that the resident was not being provided continence care as directed.

Failing to ensure that the written plan of care sets out clear direction to the staff and others providing direct care to the resident increased the risk of skin breakdown.

SOURCES: Critical incident, resident's plan of care, Interview with staff. [194]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from neglect by the licensee or staff.

Section 2 of O. Reg. 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 in action or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

SUMMARY AND RATIONALE

1. A complaint and a CI for an incident of neglect were received by the Director. The CI indicated that the resident had been found by family members requiring care.

The home's internal abuse investigation and DOC confirmed that a PSW had neglected the resident's care.

The PSW confirmed that they had entered the resident's room and observed the resident was requiring care. The PSW left the room, to inform another PSW that the resident required care and continued with their work.

The PSW failed to provide care to the resident at the time of the incident, jeopardizing the resident health, safety and well-being. The resident was placed at an increased risk and their dignity was not respected.

SOURCES: Critical Incident report, licensee abuse investigation, interview with staff. [194]

The licensee failed to ensure that a resident was protected from abuse.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

SUMMARY AND RATIONALE

2. A Critical Incident Report was submitted to the Director related to an allegation of abuse by a resident

toward another resident. The CI indicated that staff had witnessed a resident abuse another resident.

During the incident, a PSW witnessed the incident of abuse between the residents, resulting in an injury. The residents were immediately separated, and the incident was reported to the RPN.

The DOC acknowledged the physical abuse of the resident.

Failure to protect residents resulted in an injury.

SOURCES: Critical incident, review of the resident's progress notes, Interviews with staff and DOC. [741749]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

SUMMARY AND RATIONALE

A CI and a complaint were submitted to the Director related to an alleged abuse incident of a resident by staff.

A resident's progress note documented that they sustained an injury. During a non-related investigation the incident of alleged abuse was revealed to the home

The DOC acknowledged that management was made aware of the alleged abuse and the home failed to immediately submit the report to the director.

Failure to report the allegation of abuse immediately to the director put the resident at moderate risk by delaying the investigation.

SOURCES: Critical Incident, The home's internal investigation documents, Interviews with DOC and RN. [741749]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that a PSW used safe positioning techniques when assisting a resident.

SUMMARY AND RATIONALE

A CI was submitted to the Director for an alleged incident of staff to resident abuse.

The CI indicated that a resident was restless and was improperly positioned in the wheelchair.

Review of the homes video footage, revealed a PSW had improperly positioning a resident in a wheelchair.

The PSW confirmed they had improperly positioned the resident in their wheelchair to prevent a fall.

The DOC confirmed that the resident should not have been placed in this position by the PSW.

Failing to ensure that the PSW used safe positioning techniques when assisting the resident increased the risk of injury to the resident.

SOURCES: Critical Incident, licensee investigation, clinical health records for the resident and interview with staff. [194]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that a resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose when initial interventions were not effective.

RATIONALE AND SUMMARY

A CI and a complaint were submitted to the Director related to an allegation of abuse of a resident resulting in injury.

An RN indicated in the progress notes that the resident was guarding due to pain and was assessed to have an injury. The RN confirmed that the resident's scheduled pain medication was just given prior to the incident and that the as-needed pain medication was not needed at that time.

The DOC acknowledged that the home's expectation was to initiate the 72-hour monitoring tool and to utilize the pain assessment in Point Click Care when there was a new or worsening pain identified. The DOC also verified that a pain assessment tool was not completed for the resident.

The licensee's pain management program policy directed that staff initiate pain assessment when there is new pain.

Failure to ensure that resident's pain was assessed using clinically appropriate assessment imposed moderate risk to resident due to delayed intervention.

SOURCES: Critical Incident, The home's internal investigation documents, Interviews with DOC and RN, resident's Medication Administration Records, The Licensee's pain management program policy. [741749]