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: May 17, 2024

Inspection Number: 2024-1379-0001

Inspection Type:
Critical Incident
Follow up

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**
Suzanna McCarthy (000745)	Suzanna McCarthy Digitally signed by Suzanna McCarthy Date: 2024.05.22 14:58:47 -04'00'

Additional Inspector(s)
Miko Hawken (724)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29-30, May 1-2, 2024

The following intake(s) were inspected:

- Intake: #00111393 - First Follow-up to Compliance Order #001 from Inspection #2023-1379-0007- FLTCA, 2021 - s. 3 (1) 1 with a Compliance Due Date (CDD) of May 1, 2024.
- Intake: #00111394 - First Follow-up to Compliance Order #002 from Inspection #2023-1379-0007: 1 - FLTCA, 2021 - s. 30 (1) (a) with a CDD of May 1, 2024.
- One intake related to neglect

- One intake related to alleged visitor to resident financial abuse.
- One intake related to responsive behaviours.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1379-0007 related to FLTCA, 2021, s. 3 (1) 1. inspected by Suzanna McCarthy (000745)

Order #002 from Inspection #2023-1379-0007 related to FLTCA, 2021, s. 30 (1) (a) inspected by Suzanna McCarthy (000745)

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

Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care and bowel management

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to provide continence care to a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) for an incident where a resident was found to have incontinence on their body and on surfaces in their room. At a specified time, a personal support worker (PSW) arrived for their scheduled shift and smelled a mal-odorous smell when they entered the home area. The PSW observed the resident to be sleeping in their room, covered in incontinence. The PSW reported that they decided not to wake the resident to provide care and indicated that the previous shift had also left the resident to sleep to avoid disrupting the resident. The resident was not tended to for some hours.

Notes related to an investigation completed by the long-term care home (LTCH) indicate that a PSW from the previous shift had noted an odour but was unable to locate the source. According to the resident's care plan, they required continence care to be provided with a set frequency.

The PSW confirmed that the resident was not provided care immediately when they were covered in incontinence for a period of time. The Executive Director (ED) also confirmed that staff did not provide care to the resident as the home's expectation was to provide continence care immediately when the resident was soiled.

Failure to provide care immediately increased the risk of skin breakdown and

exposure to infectious disease to the resident.

Sources: CIR, LTCH investigation notes, clinical records and interviews with staff. [724]

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

In accordance with O. Reg. 246/22, neglect is defined 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.

The licensee has failed to protect a resident from neglect by two PSW's assigned to provide care.

Rationale and Summary
A CIR was submitted to the MLTC for an incident where a resident was found to be sleeping with incontinence on their body and surfaces in their room. At a specified time, a personal support worker (PSW) arrived for their scheduled shift and smelled a mal-odorous smell when they entered the home area. The PSW observed the resident to be sleeping in their room, with incontinence on their body. The PSW reported that they decided not to wake the resident to provide care and indicated that the previous shift had also left the resident to sleep to avoid disrupting the resident. The resident was not tended to for some hours.

Notes related to an investigation completed by the long-term care home (LTCH) indicate that a PSW from the previous shift had noted an odour but was unable to locate the source. According to the resident's care plan, they required continence care to be provided with a set frequency.

The PSW confirmed that the resident was neglected by not being provided care immediately when they were covered in incontinence for a period of time. The ED also confirmed that the identified PSW's had neglected to provide care to the resident as the home's expectation was to provide continence care immediately.

Failure to provide care immediately increased the risk of skin breakdown and exposure to infectious disease to the resident.

Sources: CIR, LTCH investigation notes, interviews with staff. [724]