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: April 3, 2024	
Inspection Number: 2023-1379-0007	
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 Diane Brown (110)	**Inspector Digital Signature** Diane Brown Digitally signed by Diane Brown Date: 2024.04.03 09:51:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-19, 23-25, 2024.

The following Complaint(s) and Critical Incident(s) were inspected:

- Intake related to staff retaliation from speaking with Inspector.
- Intakes related to staff to resident physical abuse.
- Intake related to concerns with staff to resident physical abuse.

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

Whistle-blowing Protection and Retaliation

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure they complied with their written policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

A complaint and Critical Incident (CI) was submitted to the Director alleging a harmful altercation of PSW #112 towards resident #001.

Resident #001 reported to RPN #110 that PSW #112 came into their room and

described how PSW #112 was harmful and inappropriate towards them. The RPN considered the residents statement as an allegation of abuse, contacted the on-call manager, police and initiated a risk management report.

A review of the resident's progress notes failed to include any documentation around the incident or resident concerns. RPN #110 stated they documented in a risk management report and not in the resident's health record, with the understanding that risk management was part of the resident's record. The DOC confirmed that the risk management report was not part of the resident's health record.

The home's policy to promote zero tolerance of abuse directed the nurse to document the suspicion in the chart of each resident involved.

Failing to document the alleged incident and suspicion in the resident's health record does not support interdisciplinary communication and transparency.

Sources: Home's policy Resident Non-Abuse, ADMIN-010.01, reviewed date March 31, 2023, resident #001's progress notes, Risk Management report and interview with resident #001, RPN #110 and DOC. [110]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the

format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure they immediately forwarded to the Director any written complaint that was received concerning the care of resident #001.

Rationale and Summary

A complainant shared that a written complaint was sent to the home around a harmful altercation and the manner in which PSW #112 addressed resident #001. The written complaint alleging the incident was forwarded to the Inspector upon request and revealed it had been sent to the Resident Services/Staff Educator (RSSE) #114. The RSSE manager confirmed receiving the email and sharing they forwarded the complaint to the DOC.

A review of the MLTC's portal LTCH.net failed to identify the complaint concerning the care of resident #001 that was sent to the home. The RSSE confirmed that the complaint had not been forwarded to the Director.

Sources: written complaint, MLTC portal - LTCH.net, interview with Resident Services/ Staff Services manager. [110]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee

knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Rationale and Summary

A complaint was received by the Director with concerns that a service provider was retaliated against after reporting a staff to resident abuse concern.

Inspector #706026 confirmed with Inspector #110 that during an inspection a service provider brought forward a concern alleging staff to resident harm. The Inspector subsequently shared the concern with ADOC #105. The ADOC could not recall if they spoke directly with the service provider to obtain specific information but relayed the information to the DOC. The DOC confirmed they heard from the ADOC but did not speak with the service provider about their concerns.

The service provider shared with Inspector #110 the incident of concern that involved resident #003, PSW #115, an approximate time frame and what they observed and heard, and that no one at the home spoke with them about their concerns to obtain this information.

An interview with the ED in place at the time, confirmed they were unaware of the incident. They indicated the manager should always speak with the individual that

had the concern and that it would be an expectation that the DOC would have followed up with the service provider.

Failure to follow-up with the service provider and initiate an investigation of an allegation of abuse left a potential abuse concern unaddressed, potentially impacting resident #003 and not promoting a culture of ensuing zero tolerance for abuse and neglect.

Sources: BSO schedule of service providers providing 1:1 resident supervision, interviews with ADOC, DOC, Inspector #706026, SG #103 and the former ED [110]

WRITTEN NOTIFICATION: Orientation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.

9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at

the home.

Inspector #706026 confirmed with Inspector #110 that during an inspection a service provider brought forward to them a concern alleging staff to resident harm and the provider did not know what to do and was afraid to bring their concern forward.

The DOC provided Inspector #110 "Revera's Annual Mandatory Training booklets signoffs" as evidence of orientation training for the third-party service provider staff. The booklets failed to provide for the required training including duty under section 28 to make mandatory reports and protections afforded by section 30 or Whistle Blowing Protection. The booklet included the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and the protections directing any person to verbally report any suspected abuse to the nurse on duty. The service provider's training booklet was signed a day after the incident had occurred.

A further review of the third-party staffing schedule that provided 1:1 resident supervision identified 24 staff had worked without receiving the required orientation training.

Failing to ensure third-party service providers received mandatory training as outlined in section 82 (2) of the Act and were not aware of the responsibilities of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, their duty under section 28 to make mandatory reports, their protections afforded by section 30 or the whistle blowing protection which resulted in an untimely reporting of an alleged staff to resident abuse.

Sources: Revera's Annual Mandatory Training booklets signoffs, A review of the 1:1

Pinakin staffing schedule for January 22-31, 2024, interview with Ministry of LTC Inspector #706026 and the DOC.[110]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee shall ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Rationale and Summary

A complaint and Critical Incident (CI) was submitted to the Director alleging a harmful and inappropriate altercation of PSW #112 towards resident #001.

The complainant shared a written complaint that was sent to the home alleging concerns of PSW #112 harmful behavior towards resident #001. The written complaint was sent to the RSSE #114. The RSSE confirmed receiving the email and shared they forwarded the written complaint to the Director of Care (DOC).

The home's complaint binder was reviewed. The review failed to identify the written complaint. An interview with the RSSE confirmed they had not documented the complaint in the binder as was expected.

Failure to document concerns, specifically the nature of the concern, action taken and response to the resident and SDM poses potential conflict in care and service relationships essential components to the quality of life of the resident.

Sources: Written complaint, home's complaint binder, interview with Resident Services/ Staff Services. [110]

WRITTEN NOTIFICATION: Screening Measures and Ongoing Declarations

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (3)
Hiring staff, accepting volunteers

s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

The licensee failed to ensure that where a police record check is required before a licensee hires a staff member as set out in subsection 81 (2) of the Act that the police record check must be a vulnerable sector check.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The home retained a third-party contractor to provide 1:1 supervision of residents. A review of a past 1:1 staffing schedule, along with BSO-RPN #100, identified 24 staff had worked over this prior period. A review of the vulnerable sector screenings provided by the DOC identified 6 out of the 24 staff with a vulnerable sector police check. The DOC confirmed the missing sector checks for all third-party contractor services.

Failure to ensure all staff had the required vulnerable sector screening places residents at risk of harm.

Sources: Staffing schedule for Pinakine 1:1 staffing, vulnerable sector screenings,

interview with BSO-RPN #100 and the DOC. [110]

WRITTEN NOTIFICATION: Resident Records

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that resident #001's written record was kept up to date at all times.

Rationale and Summary

A complaint and Critical Incident (CI) was submitted to the Director alleging a harmful and inappropriate altercation of PSW #112 towards resident #001.

Resident #001 reported to RPN #110 that PSW #112 came into their room and described how PSW #112 was harmful and inappropriate towards them. The RPN considered the resident's statement as an allegation of abuse, contacted the on-call manager, police and initiated a risk management report. The resident indicated to the Inspector they felt belittled and angry with the PSW and called and left a voicemail for RSSE #114 to share what happened. RSSE confirmed they received the resident's voice mail.

A review of the resident's progress notes failed to include any documentation of the incident reported by the resident, including documentation by the RSSE #114 of the

resident's voicemail message and details of their call. The RSSE confirmed the missing documentation.

An interview with BSO-RPN #100 who updated the resident's care plan was unaware the resident had left a voicemail.

Failure to ensure resident #001's record was kept up to date at all times, compromised accuracy and transparency of the resident's care and needs to the interdisciplinary team.

Sources: Resident #001's health record, interviews with resident #001, Resident Services/Staff educator (RSSE)#114, BSO-RPN #100. [110]

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
Upon receipt of this Order
1. Conduct an interdisciplinary managers meeting to review the grounds and Order along with the homes' policy on conducting a thorough investigation of an allegation of resident abuse. Keep a written record with the date and managers in attendance.
2. The Resident Services/Staff Educator (RSSE) shall meet with resident #001 to acknowledge that their accusation was not handled in a manner respectful to them. Keep a written record of the meeting with date and the resident's response.
3. Conduct a meeting with PSWs and registered staff on days, evenings and nights for 3 random days, to review the definitions of abuse and the expectations related to reporting. Keep a written record of the meetings with dates and staff in attendance.
4. Review and revise the residents "responsive behavior" plan of care related to "accusatory behaviors" to reflect the results of the MLTC inspection. The RSSE shall conduct a meeting with the days, evenings and night staff on the identified home area to review resident #001's revised plan of care and the requirement of Order #2. Keep a written record of the meetings with date and PSWs and registered staff in attendance.

Grounds
The licensee failed to ensure resident #001's right to be treated with respect and dignity.

Rationale and Summary

A complaint and Critical Incident (CI) was submitted to the Director alleging a harmful and inappropriate altercation of PSW #112 towards resident #001. Resident #001 reported to RPN #110 that PSW #112 came into their room and described how PSW #112 was harmful and inappropriate towards them. The RPN considered the resident's statement as an allegation of abuse, contacted the on-call

manager, police and initiating a risk management report. The resident indicated to Inspector they felt belittled and angry with the PSW and called and left a voicemail for RSSE #114 to share what happened. RSSE confirmed they received the resident's voice mail.

PSW #112 denied to Inspector their harmful interaction and altercation with resident #001 or being alone in the resident's room that shift, however co-worker PSW #113 shared that PSW #112 had been alone in resident #001's room. Video surveillance footage was observed along with the DOC and saw PSW #112 entering resident #001's room alone for just over one minute confirming an unwitnessed period of time between PSW #112 and resident #001.

PSWs #109, #104, #111 shared that the resident did not have behaviors.

According to Behavioral-Support Ontario (BSO) BSO-RPN #100, the resident's care plan was updated the day of the incident. The care plan update focused on the resident exhibiting responsive behaviors as a root cause of their allegations towards PSW #112. An interview with BSO-RPN #100 revealed they were unaware that PSW #112 had spent time alone with resident #001 that shift.

The critical incident documented the status of the resident as demonstrating behaviors as a root cause of their allegations.

The DOC shared their investigation results was unsubstantiated and that they had not initially observed the entire video surveillance of the shift to identify that PSW #112 had been alone with the resident earlier in the shift.

Resident #001 was not treated with respect and dignity when the resident's plan of care was immediately updated to indicate responsive behaviors after the resident

reported an inappropriate interaction with PSW #112 and evidence was present that the staff had been alone with the resident.

The lack of protecting resident #001 rights to be treated with respect and dignity led to the resident feeling unheard, belittled and angry.

Sources: Resident #001 plan of care, Critical Incident, video surveillance, written complaint, interviews with residents #001 and #002, PSW #112, #113, #109, #104, #111, RPN #110, Resident Services/Staff educator #114, BSO-RPN #100 and DOC. [110]

This order must be complied with by May 1, 2024

COMPLIANCE ORDER CO #002 Whistle-Blowing Protection

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 30 (1) (a)
Whistle-blowing protection
s. 30 (1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because,
(a) anything has been disclosed to an inspector;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Upon receipt of this Order:
1. Training/re-training shall be conducted with all staff, including third party contractors to review Whistle Blowing Protection afforded by the Ministry of Long - Term Care, specifically that no person shall be retaliated against another person, whether by action or omission, or threaten to do so because of anything that has

been disclosed to an inspector or anything that has been disclosed to the Director, their Duty to Report and the Ministry's Action Line toll free number. A written record of the date(s), information provided, staff names and signatures, is to be kept and made available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that no person is retaliated against another person, whether by action or omission or threaten to do so because of anything has been disclosed to an inspector.

Rationale and Summary

A complaint was received by the Director with concerns that a service provider was retaliated against after reporting a staff to resident abuse concern to a LTCH Ministry Inspector.

Inspector #706026 confirmed with Inspector #110 that during an inspection a service provider brought forward a concern alleging staff to resident harm. Inspector #706026 subsequently shared the concern with ADOC #105. The ADOC could not recall if they spoke directly with the service provider to obtain specific information but shared the service provider no longer worked at the home and believed the company let them go. The ADOC relayed the information shared by the Inspector to the DOC. The DOC confirmed they heard from the ADOC but did not speak with the service provider about their concerns.

The DOC confirmed they heard from the ADOC and called Director #106, the home's contact at the third-party service provider and shared what had occurred. The DOC asked for the staff to be retrained on the proper reporting protocols in the home. The DOC confirmed they did not speak with SG #103 directly about their

concerns and that the service provider did not return to the home.

Service provider (SP) #103, spoke with Inspector #110 and shared their worry about speaking again with an Inspector. The Whistle Blowing Protection section of the legislation and the Ministry's Action Line toll free number were provided. SP #103 shared the incident of concern that involved resident #003, PSW #115, an approximate time frame and what they observed. The SP shared that no one from the home spoke with them about their observations. SP #103 indicated that after their conversation with Inspector #706026 they had a call from their manager, Director #106, and were no longer provided scheduled shifts for two weeks and left the company.

Director #106 of the third-party service provider denied receiving a call from the DOC around concerns of SP #103. The Director indicated that SP #103 no longer works for them.

Training documents were reviewed and interviews with Staff Educator #114, DOC and Director of the third part service provider revealed that SP #103 had not been provided training, including their "duty to report" any witnessed abuse, prior to their employment in the home.

The manner in which the DOC followed up with the SP #103's manager to "reeducate the SP" after speaking with Inspector #706026, demonstrated a level of retaliation towards SP and can significantly discourage any further reporting by the third party staff and other staff in the home.

Sources: Training documents entitled "Annual Mandatory Training Handbook Quizzes and Signoffs, September 2023", BSO schedule of security guard staff services providing 1:1, interviews with ADOC, DOC, BSO- RPN, Inspector #706026,

SG #103, PSW #104, Director of Pinakine Services and complainant. [110]

This order must be complied with by May 1, 2024

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
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

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.