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
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Original Public Report

Report Issue Date: September 27, 2024	
Inspection Number: 2024-1379-0002	
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**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 13-16 and 19-22, 2024.

The following intake(s) were inspected:

- Intake: - Staff to resident neglect
- Intake:- Physical Abuse of resident by staff
- Intake: - Physical abuse of resident by staff
- Intake: - Resident to resident physical abuse
- Intake: - Staff to resident neglect
- Intake: - Fall of resident resulting in multiple fractures

The following intakes were completed in this inspection:

- Intakes - were related to falls of residents resulting in lacerations

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan of care. Specifically, the licensee has failed to ensure care for resident was done by female staff only.

Summary and Rationale

A Critical Incident Report (CIR) was submitted to the director regarding staff to resident neglect. Upon review of the LTCH investigation notes it was discovered resident #008's care preferences were not followed as outlined in the plan of care. The resident was admitted to LTCH in April, 2022.

A review of resident #008's plan of care indicated in multiple sections the preference as it relates to personal care was for females only in the areas of toileting, dressing and hygiene/grooming.

A review of the staffing list in resident #008 home area from June 22, 2024, to July 5, 2024, indicated male PSW's were assigned to resident #008 on multiple occasions.

Interview conducted with PSW #117 stated they were not aware of resident #008's care preference and had provided care to resident overnight. In a separate interview with PSW#121 they stated they were also not aware of resident #008's care preference.

The Executive Director (ED) acknowledged the resident did have a care preference which was female only for personal care which should have been followed.

By failing to follow a resident's plan of care can negatively affect the resident home experience.

Sources: Interview with PSW #117, 121, and ED. Record review Plan of care, investigation notes, schedules

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that resident #006's falls prevention plan of care was revised when care set out in the plan had not been effective.

Rationale and Summary
A Critical Incident Report was received by the Director related to fall of a resident resulting in injury.

Resident #006 had both cognitive and physical impairments and was identified at risk for falls. The resident fell in April and May, 2024 sustained an injury as result of the fall. The resident was sent to hospital and returned home. The resident continued to fall three more times and sustained multiple injuries as result of the fall. The resident was sent to the hospital and returned home.

A falls prevention plan of care was implemented for the resident, and it was revised twice in May and June, 2024. No further revision was made until after the fall on July 2024.

The goal for the resident's falls prevention plan had stated that the resident would remain free from falls through to next review. RPN #122 and ADOC #123 acknowledged that the plan had not been effective to keep the resident free from falls and that plan should have been revised.

There was increased risk and impact to the resident when the falls prevention plan of care was not revised when the care set out in the plan had not been effective.

Sources: Critical Incident clinical record, risk management fall incidents, interviews

with RPN #122, ADOC #123, Physiotherapist #120 and other staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 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 has failed to ensure that RPN #124 complied with the written policy to promote zero tolerance of abuse and neglect of residents.

In accordance with the licensee's Resident Non-Abuse policy, all persons with reasonable grounds to suspect abuse of a resident that resulted in harm to the resident must immediately report the suspicion to the person in charge, and they will immediately report the suspicion to their legislative authority.

Rationale and Summary

A Critical Incident Report was received by the Director related to alleged resident to resident physical abuse.

In May, 2024, resident #005 sustained injuries .On that day, a family member of the resident discovered the resident with injury and reported the injury and allegation to RPN #124. There were no records that indicated that the allegation of abuse of the resident was reported to management or the Director immediately on that day. The next day, the IPAC Manager was notified of the injury and allegation and the Director was notified later on in May.

The Executive Director acknowledged that staff were expected to follow the licensee's Non-Abuse policy and must immediately report the alleged abuse of resident #005 to a supervisor or manager. They also indicated that the RPN was responsible to immediately report the incident to the Director.

Failure to ensure that RPN #124 immediately report reasonable grounds to suspect abuse of a resident that resulted in harm to a resident may pose a risk of further harm.

Sources: Critical incident, clinical record, risk management, investigation notes, licensee's policy entitled Resident Non-Abuse (index: ADMIN1-P10, reviewed November 1, 2023), interview with Executive Director.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the

resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to resident #006 under that falls prevention and management program, including assessments, reassessments and interventions were documented.

Rationale and Summary

A Critical Incident report was received by the Director related to fall of a resident resulting in injury.

Resident #006 fell multiple times throughout April to June 2024. The post-fall assessments, including head injury routine and 72-hour pain monitoring were conducted by registered staff. A review of the resident's assessments conducted from the period after the falls showed that post-fall assessments were initiated but had missing documentation, including on the Glasgow Coma Scale, Vitals signs, the resident's current pain and interventions for pain. Both RPN #122 and ADOC #123 acknowledged that assessment forms were required to be completely documented.

Failure to document resident #006's assessment, reassessments and interventions as part of the licensee's falls prevention and management program impacts the oversight of staff monitoring of the resident after a fall incident.

Sources: Critical Incident, clinical record, the licensee's procedure entitled Fall Prevention and Injury Reduction Program (index CARE5-O10.05, reviewed date March 31, 2024), interviews with RPN #122 and ADOC #123.