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

Public Report

Report Issue Date: January 24, 2025

Inspection Number: 2025-1379-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15 -17, 20 - 24, 2025

The following intake(s) were inspected:

- An intake related to fall prevention and management
- An intake related to resident care and support services
- An intake related to fall prevention and management, and prevention of abuse and neglect
- An intake related to resident care and support services
- Two intakes related to prevention of abuse and neglect

The following intake was completed in the Critical Incident Systems inspection:

- An intake related to falls prevention and management

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

Resident Care and Support Services

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

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:

4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident was free from abuse from staff.

An incident of abuse involving a staff member towards a resident occurred and the home's Registered Practical Nurse (RPN) and on-call manager were made aware of the incident. The home's video footage taken on a specified date and time from a resident home area revealed the abuse. Executive Director (ED) acknowledged that the actions of the PSW towards the resident on the specified date constituted abuse.

Source: Critical incident report (CIR), home's investigation notes, video footage, resident's records, interview with ED.

WRITTEN NOTIFICATION: WHEN REASSESSMENT, REVISION IS REQUIRED

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident was reassessed, that their plan of care was reviewed and revised when their needs changed related to their transfers, and mobility. A Critical Incident report (CIR) was submitted to the Director on a specified date related to a resident's fall which resulted in an injury. Upon return from hospital, the resident was reassessed, and their transfer and mobility status changed. Review of the resident's care plan confirmed that it was not reviewed and revised to reflect the most current changes. Registered Nurse (RN) and Assistance Director of Care (ADOC)/Falls Lead confirmed that the care plan was not reviewed and revised to reflect the changes in transfers and mobility.

Sources: Resident's clinical records and interviews with RN and ADOC/Falls Lead.

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that safe transferring and position techniques were used for a resident. A CIR was submitted to the Director on a specified date related to a fall of a resident which resulted in an injury. Progress notes indicated that the resident had a specified injury upon initial assessment following the fall and was

transferred back to bed. The RN confirmed that the resident was transferred to bed via a mechanical lift with no additional support provided to the resident's specific injury. The ADOC/Falls Lead confirmed that the resident should have remained on the floor as injury was noted and the transfer was deemed unsafe.

Sources: Resident's clinical records, the home's investigation noted and interviews with an RN and ADOC/Falls Lead.

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's falls prevention and management program was implemented and followed, specifically where staff were to complete a falls risk screening assessment within twenty-four hours upon return from hospital, for a resident. In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program including policies is complied with, specifically the staff did not comply with the requirements outlined in the home's "Return from Hospitalization" policy. A CIR was submitted to the Director on a specified date related to the fall of a resident which resulted in an injury. The resident's clinical records indicated a falls risk screening assessment was not completed upon return from hospital on a specified date. The RN and ADOC/Falls Lead confirmed that the assessment was not completed.

Sources: Resident's clinical records, Return from Hospitalization, policy and interviews with a RN and ADOC/Falls Lead.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident's infectious symptoms were recorded on every shift. A resident was symptomatic and commenced a specified antibiotic on a specified date. Progress notes for the resident confirmed no documentation of the resident's signs and symptoms of infection for multiple shifts. The Director of Care (DOC) acknowledged that monitoring for signs and symptoms of infection were to be documented in a resident's progress notes every shift until antibiotics are completed. Furthermore, the DOC acknowledged that staff should have documented in resident's progress notes when the resident had started and completed the course of antibiotic treatment.

Sources: Resident's clinical records, interview with the DOC.

COMPLIANCE ORDER CO #001 RESIDENTS' BILL OF RIGHTS

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
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:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:

1. The Director of Care (DOC) or designate management staff will re-educate staff #107 and #108 on the home's policy related to the prevention of resident abuse and neglect, specifically on:
A. The definition of neglect and any aspects pertaining to ensuring residents are not neglected by the licensee or staff.
2. The DOC or designate management staff will re-educate staff #107 and #108 on the resident's bill of rights.
3. The DOC or designate management staff will re-educate all night shift UCP/PSW staff on the home's policy for safety rounds
4. The home will keep a document of the education, including the components of education, the date the education was provided, the name of the staff receiving the education, and the name of the staff member(s) who provided the education.
5. The DOC or designate management staff will conduct an audit of all night shift UCP/PSW staff three times weekly on Dunmore Park for a period of four weeks to ensure staff are completing safety rounds as per the home's Safety Rounds policy. Audits will capture the entire eight hour night shift and front-line staff will not be made aware of when auditing will occur to capture real-time results.
6. The home will keep a document of the audits completed including what is being audited, the date and time the audit was completed, the name of the staff being audited, the name of the staff conducting the audits, the outcome of the audited and the immediate corrective action taken (if any).
7. All records and documents and records will be made available to the Inspector upon request.

Grounds

The licensee has failed to ensure that a resident and the residents' of Dunmore Park, their rights to the freedom of neglect by the licensee and staff were fully respected and promoted.

Rationale and Summary

A Critical Incident report (CIR) was submitted to the Director on a specified date related to the fall of a resident which resulted in an injury. Review of the home's video footage prior to the fall and the home's investigation notes, identified that residents' safety rounds were not conducted throughout the night shift of all residents on Dunmore Park, including for a resident prior to being found on the floor.

The ED confirmed the same and substantiated neglect of the residents' on Dunmore Park as safety rounds were not conducted.

Failing to conduct safety rounds throughout the shift put the resident at risk for sustaining an injury related to a fall.

Sources: The home's investigation notes, video footage review of Dunmore Park, LTC-Safety Rounds, policy, and interview with the ED.

This order must be complied with by April 4, 2025

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.