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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 6, 2023

Inspection Number: 2023-1342-0005

Inspection Type:
Complaint

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: Burloak, Burlington

Lead Inspector	**Inspector Digital Signature**
Dusty Stevenson (740739)	Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2023.11.28 15:00:37 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12-13, 16-20, 23-24, 2023
The inspection occurred offsite on the following date(s): October 31, 2023

The following intakes were completed in this complaint inspection:

- Intake: #00094860 – related to falls prevention and management, prevention of abuse and neglect.
- Intake: #00096647 – related to resident care and support services.

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: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to comply with the post-fall management procedure to contact a resident's substitute decision maker (SDM) when the resident had a fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program must be complied with.

Specifically staff did not comply with the home's Post-Fall Management procedure, which was captured in the home's Fall Prevention and Injury Reduction Program.

Rationale and summary

A resident had an unwitnessed fall. According to a record review of the resident's clinical records, the resident's SDM was not contacted to inform them of the fall. The SDM called the home on the following day to check-in with the resident and this is when the home informed the SDM of the fall.

The DOC indicated that as part of their post fall procedure, it was the expectation that the staff contact the resident's SDM immediately following a fall.

Sources: Resident's clinical records, interview with the DOC, home's Fall Prevention and Injury Reduction Program
[740739]

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee failed to follow the home's procedure for acquisition and administration of a medication for a resident.
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the medication management system has written policies and protocols developed for medication acquisition and

administration, and must be complied with.

Specifically, staff did not comply with the home's Medication Administration procedure, which is captured in the home's Medication Management policy.

Rationale and summary

According to records, a resident was ordered to have a medication post-operatively from for a specific number of days. The resident's electronic medication administration record (eMAR) indicated that when they returned from hospital that the resident did not receive the medication for the duration of time as specified in the order.

According to the home's Medication Administration procedure, the pharmacy provider will be notified if ordered medication is not available for administration. The Physician/Nurse Practitioner will be notified if medication is not available and determine an alternate plan.

The home's internal investigation into the incident revealed they were unable to locate a reorder record for the medication and confirmed with their Pharmacy that they did not receive a reorder, nor did staff notify the physician when the medication was not available.

The DOC indicated the procedure was not followed for when a medication was not available.

The resident's physician was interviewed by inspector #740739 and they indicated that the resident was to receive the medication post-operatively and if medications were unavailable then staff would contact them for an alternative.

As a result, post-operative medication orders were not followed, which may have placed the resident at increased risk of medical complications.

Sources: Resident's clinical records, interview with the DOC and physician, home's internal investigation notes
[740739]

COMPLIANCE ORDER CO #001 Duty of licensee to comply with plan

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

The licensee shall:
-Ensure residents who require 1:1 monitoring are scheduled with staff and create contingency plan for when coverage isn't available.
-Ensure two specific staff members are educated on the procedure for starting/ending shift and taking breaks when providing 1:1 monitoring so there is no gap of coverage.
-Document the education and retain record of education provided.

Grounds
The licensee failed to ensure a resident was provided 1:1 care, 24-hours a day when they required it to reduce their risk for falls.

Rationale and summary

A resident had a fall and was hospitalized for their injury. The resident returned to the home and 1:1 staff was in place 24-hours a day to reduce their risk for falls.

On a specified day a staff member was providing 1:1 monitoring for the resident. At a specific time that day, the resident was found on the floor in their room and there was no 1:1 staff present when the resident fell. The staff member providing 1:1 monitoring did not witness the fall as they had gone to the washroom and had not arranged for coverage while they were absent. The resident was assessed by the nurse and no injuries were found.

On a different day the home's staffing complement indicated the resident had 1:1 monitoring scheduled however there was a two-hour period where no staff was scheduled. During this two-hours, a nurse documented they completed safety rounds on the resident and when interviewed by the inspector they indicated no 1:1 staff was in the room at the time of their check. Later that day another staff member was scheduled to start their shift as 1:1 for the resident. When interviewed, the staff member indicated that when they arrived for their shift they did not go directly to the resident's room and instead went to the nursing station for report and then proceeded to go to the resident's room. It was at this time that the staff member discovered the resident had passed. They indicated there was no 1:1 in the room when they arrived.

When interviewed, the DOC indicated that when no staff was scheduled for the resident other staff were to provide coverage. The DOC stated that staff providing 1:1 monitoring were not to attend report at the beginning of their shift, they were to go directly to the room of the resident they are providing 1:1 for.

As a result, the resident had an unwitnessed fall for which a 1:1 was in place to prevent. And on a

different day, a 1:1 staff was not accounted for during a time period at which time the resident was found unresponsive by a staff member.

Sources: Resident's clinical records, interviews with staff, home's staffing complement.
[740739]

This order must be complied with by December 1, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.