Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 22, 2019	2019_749653_0017 (A1)	007555-17, 008236-17, 009060-17, 010057-17, 011590-17, 018188-17, 019813-17, 023859-17, 004553-18, 027319-18, 030619-18, 004829-19, 004830-19, 004831-19, 004832-19, 004833-19, 004834-19, 005794-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Elginwood
182 Yorkland Street RICHMOND HILL ON L4S 2M9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by ROMELA VILLASPIR (653) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Corrections were made to the staff numbers cited under the s. 36 finding.

Issued on this 22nd day of July, 2019 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by ROMELA VILLASPIR (653) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, and July 2, 3, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

CIS intakes related to falls:

Log #(s): 007555-17, 010057-17, 011590-17, 018188-17, 023859-17, 004553-18, 027319-18, 005794-19.

CIS intakes related to abuse:

Log #(s): 008236-17, 009060-17,

#019813-17 related to unsafe transfer,

#030619-18 related to a medication incident.

Follow-up Log (#s):

004834-19 related to Compliance Order (CO) #001, issued to the licensee on February 26, 2019, within inspection report #2018_414110_0012 under LTCHA, 2007, c.8. s. 6. (1) Plan of Care, was inspected.

004831-19 related to CO #002, issued to the licensee on February 26, 2019, within inspection report #2018_414110_0012, under O. Reg 79/10, s. 8. (1) (b) Policies, was inspected.

004832-19 related to CO #003, issued to the licensee on February 26, 2019, within inspection report #2018_414110_0012, under O. Reg 79/10, s. 31 (3) Nursing and Personal Support Services, was inspected.

004830-19 related to CO #004, issued to the licensee on February 26, 2019, within inspection report #2018_414110_0012, under O. Reg 79/10, s. 33. (1) Bathing, was inspected.

004829-19 related to CO #005, issued to the licensee on February 26, 2019, within inspection report #2018_414110_0012, under O. Reg 79/10, s. 131. (2) Administration of Drugs, was inspected.

004833-19 related to CO #006 issued to the licensee on February 26, 2019, within inspection report #2018_414110_0012 under LTCHA, 2007, c.8. s. 6. (7) Duty of Licensee To Comply With Plan, was inspected.

During the course of the inspection, the inspector(s) conducted observations of resident care provision, staff and resident interactions, reviewed clinical health records, staff training records, staffing schedules, staff employment records, internal audits related to the COs, the home's Critical Incidents (CI) binder, and internal investigation records.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Agency Registered Staff, Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #005	2018_414110_0012	653
O.Reg 79/10 s. 31. (3)	CO #003	2018_414110_0012	110
O.Reg 79/10 s. 33. (1)	CO #004	2018_414110_0012	110
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2018_414110_0012	648
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #006	2018_414110_0012	648
O.Reg 79/10 s. 8. (1)	CO #002	2018_414110_0012	653

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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 be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to fully respect and promote resident #001's right to be properly cared for in a manner consistent with their needs.

The home submitted a Critical Incident Report (CIR) to the Director, related to unsafe transfer resulting in injury of resident #001.

During an interview with resident #001 in regards to the critical incident, they had mentioned a recent incident wherein they were left unattended after Personal Support Worker (PSW) #107 answered their call bell during an identified shift. Resident #001 stated they had experienced identified clinical symptoms and initiated their call bell to alert staff, and repeatedly continued to ring the call bell until staff responded after an extended period of time. Resident #001 stated PSW #107 responded to their call bell, and asked the PSW to contact the Registered Practical Nurse (RPN) for medication. Resident #001 stated they did not receive their medication until the beginning of the following shift, stating that until this time they continued to feel unwell, were unable to rest, and were very upset that staff did not respond in a suitable time frame to provide treatment in order to alleviate thier discomfort.

A review of resident #001's clinical records identified an order for an identified medication, and the electronic Medication Administration Record (eMAR) indicated it was provided by RPN #101 on an identified date and time.

During an interview, PSW #107 indicated they worked during the identified shift and responded to resident #001's call bell. The resident reported to them that they were feeling unwell. PSW #107 stated they immediately informed RPN #106 who was in the hallway as PSW #107 exited resident #001's room. PSW #107 stated that agency PSW informed them resident #001 continued to feel unwell shortly before the following shift started, but did not follow up or speak to RPN #106 for the remainder of the shift, and did not communicate this to the oncoming shift before leaving the home area.

An interview with RPN #106 indicated they were informed by PSW #107 that resident #001 complained of identified clinical symptoms. RPN #106 reported they observed resident #001 lying in their bed at an identified time, and stated that the resident did not look like they were in distress. RPN#106 revealed they were aware of resident #001's medication for the identified clinical symptoms, but did not provide it at the time as the resident looked okay.

An interview with RPN #101 indicated they worked during the following shift and acknowledged PSW #103 reported resident #001 was unwell, complaining of identified clinical symptoms at the beginning of the shift. RPN #101 stated they provided the medication as noted in the resident's physician orders. RPN #101 spoke with resident #001, and stated the resident expressed they were unwell

and upset they had to wait for administration of their medication.

The resident's concerns, staff interviews, and identified records were reviewed with the Director of Care (DOC). The DOC acknowledged resident #001s call bell was not answered in a suitable time frame, and that the resident was not provided the medication as requested within an appropriate period of time as a treatment for their clinical symptoms. The DOC further acknowledged resident #001's right to be properly cared for in a manner consistent with their needs was not respected and promoted. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

The home submitted a CIR to the Director related to unsafe transfer resulting in injury of resident #001. The CIR indicated the resident sustained a fall during a transfer using an identified equipment, resulting in an injury.

Resident #001's clinical records at the time of the reported critical incident were reviewed. Resident #001's identified assessment indicated they required an identified type of assistance for all Activities of Daily Living (ADLs) including transfers with the use of an equipment. An interview with resident #001 indicated PSW #104 was providing care while using the equipment, when they noticed something disconnected from it and they fell.

A review of the staffing schedule identified PSWs #146, #108, and #104, were working in resident #001's home area during the identified shift. PSW#146 was unavailable for interview during the inspection. An interview with PSW #108 confirmed they were present but were not assigned to resident #001's care at the time. PSWs #108 and #104 stated they were aware of resident #001's transfer assistance with the use of equipment. PSW #104 further indicated they provided care to resident #001 and confirmed they carried out the transfer unsafely resulting in resident #001's fall. PSW #104 acknowledged they used unsafe transfer techniques which put the resident at risk and resulted in a fall.

Resident #001's clinical records, staff and resident interviews were reviewed with the home's DOC. The DOC acknowledged the home's staff did not use safe transferring techniques at the time of resident #001's transfer. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a written plan of care for resident #002 that sets out clear directions to staff and others who provided direct care to the resident.

The Ministry of Long-Term Care (MLTC) received a CIR following the identification of an injury sustained from a fall. The CIR identified resident #002 sustained a fall during an identified shift where they were found sitting on their bed with injuries noted. The resident was transferred to hospital and was discharged from the home.

A review of resident #002's written plan of care identified the resident required an identified type of assistance for an identified care, and was to have a schedule.

Interviews with PSW #116 and RPN #112 did not indicate resident #002 had a schedule in place for the identified care provision, and further acknowledged the written plan of care did not provide clear directions to staff.

An interview with the home's DOC identified that individualized schedules for the identified care provision were organized in the home following the assessment of residents. The schedule was then populated in the written plan of care to direct staff for individualized schedules for residents in the home. The DOC acknowledged the home failed to ensure that resident #002's written plan of care sets out clear directions to staff who provided direct care to the resident.

Non-compliance was found under LTCHA, 2007, c.8. s. 6. (1) within inspection report #2018_414110_0012 and a compliance order was issued to the home on February 26, 2019. It had been confirmed through current inspection #2019_749653_0017 that the non-compliance found under LTCHA, 2007, c.8. s. 6. (1) had been addressed and complied by the home since the noncompliance occurred in September 2018. Therefore, a written notification will be issued within this inspection #2019_749653_0017. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a drug was administered to resident #025 in accordance with the directions for use specified by the prescriber.

The home had called the MLTC after hours infoline and subsequently submitted a CIR related to a medication incident involving resident #025 which resulted in hospitalization. The CIR indicated on an identified date, the resident exhibited identified clinical symptoms. The registered staff notified the attending physician and ordered to send the resident to the hospital to rule out an identified medical condition. The attending physician believed the resident's condition was due to an identified drug being held in an identified shift, and that the medication should not have been held.

A review of resident #025's physician's digiorder indicated specific instructions related the administration of an identified drug, including the circumstance under which the drug would be held by registered staff.

A review of resident #025's eMAR indicated the scheduled drug was held on an identified date and time by RPN #115, but not as directed by the prescriber.

During an interview, RPN #115 stated they could not recall the above mentioned medication incident, but acknowledged that based on their documentation, it was a medication error and that the drug was not administered to resident #025 in accordance with the directions for use specified by the prescriber.

During an interview, the DOC acknowledged the drug was not administered to resident #025 in accordance with the directions for use specified by the prescriber when RPN #115 held the drug. The DOC further indicated resident #025's condition was stable after they had returned from the hospital.

Non-compliance was found under O. Reg 79/10, s. 131. (2) within inspection report #2018_414110_0012 and a compliance order was issued to the home on February 26, 2019. It had been confirmed through current inspection #2019_749653_0017 that the non-compliance found under O. Reg 79/10, s. 131. (2) had been addressed and complied by the home since the noncompliance occurred in November 2018. Therefore, a written notification will be issued within this inspection #2019_749653_0017. [s. 131. (2)]

Issued on this 22nd day of July, 2019 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.