Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 02, 2023	
Inspection Number: 2023-1354-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Elginwood, Richmond Hill	
Lead Inspector Parimah Oormazdi (741672)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8 - 12, and 15, 2023

The following intake(s) were inspected:

- Intake: #00017476 was related to pain management and skin and wound prevention and management.
- Intake: #00019103 was related to unknown cause of injury.
- Intake: #00019168 was related to prevention of abuse and neglect.
- Intake: #00022419 was related to improper transferring and positioning

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Pain 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) 1.

The licensee has failed to ensure that a resident is treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their existing responsive behaviours.

Rationale and summary:
A complaint was submitted to the Director related to concerns of a Registered Practical Nurse (RPN) providing care to a resident. The resident exhibited responsive behaviours and the RPN had multiple interactions with the resident when they wanted to respond to their behaviour. The home had conducted an investigation on the RPN's behaviour toward the resident and it was identified that the RPN has been behaving disrespectfully toward the resident when they wanted to warn the resident of their behaviour.

The resident who was cognitively intact, stated that they found the RPN disrespectful and they were emotionally affected with the way the RPN talked to them.

The RPN confirmed that they talked to the resident disrespectfully when they wanted to respond to their behaviour. They stated they wanted to be firm with the resident in order to prevent them from repeating their behaviour. The Director of Care (DOC) stated that the resident should have been respected in any circumstances and the RPN's behaviour was not acceptable.

Failure to respect the resident, resulted in not following the resident's bill of rights and made the resident feel emotionally distressed.

Sources: Home's investigation notes, the resident's clinical notes, interviews with the resident, RPN and DOC.
[741672]

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure the staff involved in the care of a resident collaborated with each other in their pain assessment.

Rationale and summary:
A resident was discovered with a skin integrity of unknown cause and later it was confirmed that they sustained an injury. The Long-Term Care Home's (LTCH) investigation notes revealed that during that time frame, a Personal Support Worker (PSW) did not report to the registered nurse when the resident was complaining of pain through providing care. They falsely documented in the resident's electronic chart that they were not in pain. As a result, the registered nurse was not aware of the resident's pain and did not complete the pain assessment and treat them with the appropriate strategies and interventions for their pain.

The home's policy titled, Health Records and Documentation stated "A resident's record should be factual, internally consistent, concise and accurate and not include, editorial comments, speculation or meaningless phrases."

The PSW indicated that they did not report to the registered nurse when the resident was complaining of pain through providing care and did not document accurately in the resident's electronic chart. The DOC confirmed that the PSW and the registered nurse must collaborate with each other in the pain assessment of the resident, so that the registered nurse could take required actions for managing their pain. They also indicated that the resident's pain should have been documented accurately, so it would have notified the registered nurse to take the required actions.

Lack of collaboration between the PSW and registered nurse in the pain assessment of the resident, put them at risk of increased pain and discomfort.

Sources: Resident's clinical notes, interviews with PSW and DOC, Health Records and Documentation policy, ADMIN4-O10.02, last revised on March 31, 2022.
[741672]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect the resident from neglect when a diagnostic test was not completed in a timely manner.

Section 7 of Ontario Regulation 246/22 defines "Neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and summary:
A PSW discovered an impaired skin integrity on a resident's body through the provision of care and reported to the registered nurse. The physician was notified, and they ordered a diagnostic test to rule out injury. The Nurse Practitioner (NP) also assessed the resident on the following day and they added another diagnostic order in addition to the physician's order. However, both orders were not completed until approximately one week later, when the injury was confirmed. As a result, the treatment for the injury was delayed and the skin status deteriorated.

The two RPNs indicated that the completion of diagnostic test for the resident was delayed since no technician was sent to the home from the diagnostic centre during that one week. There was no documentation on the resident's electronic progress notes to indicate the delay and follow up with the diagnostic centre to ensure they would attend the home for completion of the diagnostic orders in a timely manner.

The DOC indicated when the registered nursing staff has recognized the diagnostic test for the resident was delayed, they should have followed up with the diagnostic centre. They confirmed that there was neglect in completion of the orders in a timely manner and has delayed the diagnosis of the injury.

Failure to complete the diagnostic test for the resident in a timely manner, put them at increased risk of worsening injury and overall health status.

Source: The resident's clinical notes, interviews with the PSW, two RPNs and the DOC
[741672]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when only one staff assisted a resident for their transfer when they required more than one staff assistance for transferring.

Rationale and summary:
A Critical Incident (CI) report was submitted to the Director, when a resident was transferred to hospital due to an unknown cause of injury and returned to the LTCH with significant change in status. The LTCH's investigation identified that the resident was transferred multiple times to different surfaces

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using a transfer equipment with only one staff assistance. The resident's care plan indicated that they required transfer equipment and more than one staff assistance for transferring. As a result, the resident had an impaired skin integrity on their body and later was diagnosed with an injury.

The DOC stated that the expectation of the home was to transfer residents with two staff assistance when a specific transfer equipment was used for transferring.

Failure to follow safe transferring techniques, has put the resident at increased risk of injury.

Source: CI report, the resident's clinical notes, investigation notes, interview with the DOC
[741672]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

The licensee has failed to ensure that the resident’s responses to and the effectiveness of pain management strategies were monitored.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program, at a minimum, provides for the monitoring of residents’ responses to, and the effectiveness of, the pain management strategies and must be complied with.

Rationale and Summary:
The NP has assessed a resident due to the report of impaired skin integrity on their body and ordered pain monitoring in a particular time frame. However, there was no records of pain monitoring and the effectiveness of pain medication on one of the days within that time frame. Furthermore, the resident’s pain monitoring tool had no documentation related to the monitoring of the effectiveness of the pain medication, when a pain medication was administered.

The home's policy titled, Pain Assessment and Management stated “Upon completion of the Pain Screening Scale, all residents with identified pain must have pain monitoring tool initiated and completed. The effectiveness of pain interventions is monitored, and resident outcomes are evaluated and documented.”

The RPN indicated that effectiveness of pain management medications, would be documented utilizing the electronic Medication Administration Record (eMAR) and the pain monitoring tool. The DOC confirmed that the interventions were not monitored for effectiveness and the documentation was

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incomplete in both the progress notes and on the pain monitoring tool on those particular days. They indicated that the missing documentations would cause inconsistency in pain monitoring for the resident. As a result, the resident was at risk for increased pain and discomfort when the pain interventions were not monitored for effectiveness.

Sources: The resident's medical records, Pain Assessment and Management policy, CARE8- P10, last revised on March 31, 2023, interviews with the RPN, the NP and the DOC.
[741672]