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: March 20, 2024
Inspection Number: 2024-1354-0001
Inspection Type: 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: Elginwood, Richmond Hill

Lead Inspector	**Inspector Digital Signature**
Fatemeh Heydarimoghari (742649)	
Additional Inspector(s) Natalie Jubian (000744)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6 to 8, 11, 2024

The following critical incident(s) were inspected:

- Intakes related to injury of unknown cause
- Intakes related to resident fall with injury
- Intake related to an alleged staff to resident neglect

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect resident #002 from neglect by a staff member.

Section 2 of O. Reg. 246/22 s. 7 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 in action or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a complaint from a resident's Substitute Decision Maker (SDM). The complaint alleged a staff member had assisted the resident to the washroom with their pants below their

knees. Subsequently, the resident sustained a fall.

The home's investigation notes indicated the staff member had assisted the resident to the washroom with their pants below their knees, and subsequently fell. The staff member requested assistance from another staff member to lift the resident off the floor and assisted them to the dining room. The staff member did not notify the nurse on duty prior to assisting the resident off the floor.

The home's "Post-Fall Management" policy indicated upon discovering a resident who has fallen, the resident is not to be moved until an assessment is completed by the nurse. The PSW did not inform the nurse in charge until after the resident was taken to the dining room, delaying an assessment to the resident post-fall.

The Director of Care (DOC) confirmed neglect was substantiated through the home's investigation as the staff member had assisted the resident to the washroom with their pants below their knees and did not immediately notify the nurse on duty of the resident's fall, delaying an assessment.

Failing to safely assist and reporting the resident's fall to the nurse immediately, placed the resident at risk for injury.

Sources: CIR, home's investigation notes, home's policy titled "Post-Fall Management", interview with DOC. [000744]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 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.

1) The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A CIR was submitted to the Director related to a written complaint made by a resident's SDM.

The complaint was sent to the Long-Term Care Home (LTCH) which indicated a staff member had assisted a resident to the washroom with their pants below their knees. Subsequently, the resident sustained a fall. The LTCH investigation notes indicated the staff member requested help from another staff member to lift the resident off the floor without use of a mechanical lifting device.

The home's "No Manual Lift Directive" indicates staff will use a mechanical lifting device to lift residents from the floor who have fallen. Associate Director of Care (ADOC) #106, Registered Practical Nurse (RPN) #105, and Personal Support Worker (PSW) #104 indicated the "No Manual Lift Directive" was in place for the safety of the residents as there could be a possible injury to a resident after they have fallen. The DOC confirmed the resident was lifted off the ground without use of a mechanical lift, which was unsafe.

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

Sources: CIR, home's investigation notes, the home's policy titled "No Manual Lift Directive", interviews with staff. [000744]

2) The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A CIR was submitted to the Director regarding the unknown cause of a resident's injury.

The home's" Safe Resident Handling Policy" stated that two staff must be present at all times while the mechanical device is in operation. The home's internal investigation notes indicated that a staff member used the mechanical lifting device for transferring the resident by themselves. The DOC and Physiotherapist (PT) confirmed that the staff member did not use safe transferring when assisting the resident.

Failing to ensure that the staff used safe transferring techniques placed the resident at an increased risk of harm and injury.

Sources: CIR, resident's clinical records, home's policy titled Safe Resident Handling, Interview with the DOC and PT. [742649]