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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 14, 2023
Original Report Issue Date: June 27, 2023
Inspection Number: 2023-1087-0003 (A1)
Inspection Type: Follow up Critical Incident System
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Fox Ridge Care Community, Brantford

Amended By Jennifer Allen (706480)	**Inspector who Amended Digital Signature** **Jennifer Allen (706480)**

AMENDED INSPECTION SUMMARY

This report has been amended to: Extend the compliance due date to August 11, 2023, as per the request of the home.

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report (A1)

Amended Report Issue Date: July 14, 2023	
Original Report Issue Date: June 27, 2023	
Inspection Number: 2023-1087-0003 (A1)	
Inspection Type: Follow up Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Fox Ridge Care Community, Brantford	
Lead Inspector Pauline Waldon (741071)	**Additional Inspector(s)** Jennifer Allen (706480) Erin Denton-O'Neill (740861)
Amended By Jennifer Allen (706480)	**Inspector who Amended Digital Signature** Jennifer L Allen Digitally signed by Jennifer L Allen Date: 2023.08.02 11:19:31 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: Extend the compliance due date to August 11, 2023, as per the request of the home.

INSPECTION SUMMARY

Intake Details
The inspection occurred onsite on the following date(s): June 6 - 8, 12 - 16, 19 - 21 and 23, 2023.
The inspection occurred offsite on the following date(s): June 9, 2023.

The following intake(s) were inspected:

- Intake: #00001122 - CI: 2570-000030-22 - Related to abuse.
- Intake: #00002241 - CI: 2570-000020-22 - Related to hypoglycemia.

- Intake: #00006082 - CI: 2570-000007-22 - Related to hypoglycemia.
- Intake: #00006516 - CI: 2570-000010-22 - Related to hypoglycemia.
- Intake: #00011462 - CI: 2570-000036-22 - Related to abuse.
- Intake: #00018344 - CI: 2570-000002-23 - Related to neglect.
- Intake: #00018457 - CI: 2570-000003-23 - Related to falls prevention management.
- Intake: #00019391 - CI: 2570-000004-23 - Related to injury resulting in a significant change in health status.
- Intake: #00020065 - CI: 2570-000005-23 - Related to an unexpected death.
- Intake: #00022585 - CI: 2570-000009-23 - Related to abuse.
- Intake: #00022743 - CI: 2570-000010-23 - Related to falls prevention management.
- Intake: #00086586 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7)
- Intake: #00086587 - Follow-up #: 1 - O. Reg. 79/10, s. 50 (2) (b) (iv)
- Intake: #00086588 - Follow-up #: 1 - O. Reg. 246/22 - s. 123 (3) (a)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1087-0002 related to FLTCA, 2021, s. 6 (7) inspected by Erin Denton-O'Neill (740861)

Order #001 from Inspection #2023-1087-0002 related to O. Reg. 79/10, s. 50 (2) (b) (iv) inspected by Erin Denton-O'Neill (740861)

Order #003 from Inspection #2023-1087-0002 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Erin Denton-O'Neill (740861)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 174.1 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, that the Minister's Directive was complied with.

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, Effective April 15, 2020, the Licensee was required to ensure under section 8. (1) 1., that the Director was informed of a resident who was administered glucagon which resulted in the resident being taken to a hospital, no later than one business day after the occurrence of the incident.

Rationale and Summary:
A resident had a hypoglycemic reaction, was administered glucagon, and transported to hospital. The Critical Incident Report (CI) was not submitted to the Ministry until twelve business days after the incident.

There was no risk to the resident as a result of this.

Sources: Resident's progress notes, CI #2570-000010-22, and interview with the Associate Director of Care (ADOC)

[741071]

WRITTEN NOTIFICATION: Plan of Care - Revised

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (a)

The licensee failed to ensure that a resident's written plan of care was revised when the resident's skin integrity care needs changed.

Rationale and Summary:
A resident sustained two areas of altered skin integrity. The resident's care plan at the time did not include a skin care focus for either wound area.

Failure to revise the resident's written plan of care may have put the resident at risk by not communicating to other staff/disciplines the interventions required to ensure the resident's skin care needs were met.

Sources: Resident's electronic health records, interviews with staff and the Quality Manager.

[706480]

WRITTEN NOTIFICATION: Transferring and Positioning

NC #003 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 assisting a resident.

Rationale and Summary:
According to the resident's progress notes and the home's internal investigation notes, a staff member transferred the resident by themselves, left the resident unattended and the resident fell. The staff member attested that they also lifted the resident by themselves after the fall, prior to a nurse assessment.

The resident's care plan at the time of the fall, required two staff assistance and the Lift and Transfer Assessment stated the resident required a mechanical lift.

The home's Falls Prevention and Management policy stated when a fall occurs, all team members will ensure the resident is not moved before the completion of a preliminary assessment.

Failing to ensure that staff used safe transfer techniques resulted in significant injury to the resident.

Sources: Falls Prevention and Management (ID#VII-G-30.10, last review April 2023); resident's clinical health records; interviews with staff and the ADOC.

[706480]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.

The licensee failed to ensure that when a resident sustained altered skin integrity, that treatments and interventions were initiated.

Rationale and Summary:
A resident sustained alterations to their skin integrity.

Upon review of the resident's health records, including the physician orders, medication administration records and the care plan, there was no record of a skin care treatment being entered for the altered skin integrity.

The resident's progress notes indicated that their altered skin integrity was assessed by the physician and the registered staff.

Failure to initiate a treatment order for the resident's wounds, may have delayed treatment and healing and compromised administration accuracy and resident safety.

Sources: Resident's health records; CI #2570-000036-22 report; interview with the Quality Manager.

[706480]

WRITTEN NOTIFICATION: Dietary Referral

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

The licensee failed to ensure that when a resident exhibited altered skin integrity, that the resident was assessed by a registered dietician.

Rationale and Summary:
The home's Skin & Wound Care Management Protocol stated with a resident exhibiting altered skin

integrity, a dietary referral to the Dietitian is to be initiated.

The resident had an area of altered skin integrity. The resident's clinical records indicated that a dietary referral was not initiated and no record of the Dietitian assessing the resident due to the injuries was found.

Failure to initiate a dietary referral increased the risks for impaired skin integrity and wound healing.

Sources: Skin & Wound Care Management Protocol (ID#VII-G-10.92, last reviewed November 2021); resident's clinical health records; interviews with staff, Quality Manager and the Executive Director.

[706480]

WRITTEN NOTIFICATION: Repositioning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

The licensee has failed to ensure that a resident, who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required.

Rationale and Summary:
A resident required two staff extensive assistance for mobility and total assistance for transferring.

The resident’s current plan of care for skin care needs, included a turning and repositioning program every two hours.

The Body Alignment & Positioning policy stated that the registered staff will create a positioning/turning schedule for the resident who is not able to reposition themselves, and that the care team will reposition the resident at regular intervals for those who cannot reposition themselves in bed/chair at minimum every two hours.

Inspector #706480 observed the resident, and the resident was not repositioned for two hours.

By failing to turn and reposition the resident every two hours, pressure to the resident's skin may not have been offloaded, therefore, increasing the risk of skin breakdown.

Sources: Resident's clinical health records; interviews with staff and the ADOC.

[706480]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Educate all Personal Support Workers on the definitions of abuse and neglect, and the legislative requirements pertaining to the prevention of abuse and neglect of residents including, but not limited to, the procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

2. Keep a documented record of the education provided, including who received the education, the date of when the education was completed and the contents of the education and training materials for inspector review.

Grounds:
The licensee failed to ensure that a resident was protected from neglect by staff and that a second resident was protected from physical abuse by another resident.

A. 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 staff member transferred a resident and left that resident unattended. Upon returning to the resident's room, the resident had fallen.

The home's Prevention of Abuse & Neglect of a Resident policy stated all residents have the right to be free from neglect and the home had a Zero Tolerance policy of neglect by its team members.

The ADOC confirmed that the home's internal investigation concluded that the staff member did not follow the plan of care and left the resident in an unsafe situation that put the resident's safety at risk.

Failure to protect the resident from neglect caused actual harm to the resident's health and wellbeing.

Sources: CI #2570-000002-23, the home's investigation notes, Prevention of Abuse and Neglect of a Resident Policy (VII-G-10.00, last revised October 2022); interviews with staff and the ADOC.

[706480]

B. Subsection (2) (c) of Ontario Regulation 246/22 defines 'physical abuse' as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
A resident sustained a physical injury when a second resident acted inappropriately towards them. The second resident had a history of responsive behaviours towards other residents and staff at the time of the incident.

The home's Prevention of Abuse and Neglect of a Resident Policy stated all residents have the right to dignity, respect, freedom of neglect and protection from abuse.

Failure to protect the resident from the altercation, resulted in injury to the resident.

Sources: Resident's clinical health records; Prevention of Abuse and Neglect of a Resident Policy (VII-G-10.00, last revised 10/2022); interviews with staff and the Quality Manager.

[706480]

This order must be complied with by August 11, 2023.

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.