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

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

Original Public Report

Report Issue Date: September 10, 2024
Inspection Number: 2024-1087-0003
Inspection Type: Critical Incident Follow-up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Fox Ridge Community, Brantford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21, 22, 23, and 26, 2024.

The following intake(s) were inspected:

- Intake: #00117225/Critical Incident System report #2570-000016-24 related to falls prevention and management.
- Intake: #00119098/Follow-up #1 related to Compliance Order (CO) #001 from inspection #2024_1087_0002, FLTCA, 2021, s. 24 (1), duty to protect, with a Compliance Due Date (CDD) of August 1, 2024.
- Intake: #00119099/Follow-up #1 related to CO #002 from inspection #2024_1087_0002, O. Reg. 246/22, s. 53 (1) 2., skin and wound care, with a CDD of July 26, 2024.
- Intake: #00119100/Follow-up #1 related to CO #004 from inspection #2024_1087_0002, O. Reg. 246/22, s. 54 (1), falls prevention and management with a CDD of July 26, 2024.
- Intake: #00119101/Follow-up #1 related to CO #003 from inspection #2024_1087_0002, O. Reg. 246/22, s. 55 (1) 3., skin and wound care, with a CDD of July 26, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1087-0002 related to FLTCA, 2021, s. 24 (1)
inspected by Julie Lampman (522)
Order #002 from Inspection #2024-1087-0002 related to O. Reg. 246/22, s. 53 (1) 2.
inspected by Julie Lampman (522)
Order #003 from Inspection #2024-1087-0002 related to O. Reg. 246/22, s. 55 (1) 3.
inspected by Julie Lampman (522)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #004 from Inspection #2024-1087-0002 related to O. Reg. 246/22, s. 54 (1)
inspected by Julie Lampman (522)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary
A) A Critical Incident System report was submitted to the Director related to a fall that a resident sustained.

The resident's care plan indicated that they required a specific falls prevention intervention.

The Director of Care (DOC) stated that the resident did not have the intervention in place when they fell, and this had been identified to have been a potential contributing factor to their fall.

B) The resident's care plan indicated that they required another falls prevention intervention in place.
During the inspection, the Inspector observed that the falls prevention intervention was not in place for the resident.

Assistant Director of Care (ADOC) #102 stated that the resident should have had the falls prevention intervention in place.

There was risk for falls and injury when the resident did not have the falls prevention interventions in place.

Sources: Observations of the resident; review of the resident's clinical records; and interviews with ADOC # 102 and the DOC.

WRITTEN NOTIFICATION: Conditions of Licence

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with the conditions to which the licensee was subject related to Compliance Order (CO) #004 from inspection #2024_1087_0002 for O. Reg. 246/22 s.54 (1), related to Head Injury Routines (HIRs) with a Compliance Due Date (CDD) of July 26, 2024.

Rationale and Summary
CO #004 from inspection #2024_1087_0002 stated that the licensee was to complete daily audits to ensure that HIR forms were completed and documented accurately for the residents that met the criteria for HIR monitoring. The licensee was to maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until the order was complied.

The home's HIR Monitoring form indicated that staff were to initiate a HIR for all unwitnessed falls and witnessed falls that resulted in a possible head injury. Staff were to monitor and document the resident's pulse, respirations, blood pressure, pupil reaction, level of consciousness, limb and/or involuntary body movement, evidence of nausea, vomiting, headache, change in mental status immediately at time of injury and as scheduled:

- every (q) 30 minutes x 1 hours;
- q 1 hours x 4 hours;
- q 8 hours x 56 hours or until directed by the physician to cease monitoring.

A) A resident had an unwitnessed fall. There were no dates recorded on the resident's HIR form. The HIR was initiated 30 minutes after the fall, not immediately. The next 30 minute check was completed 1.5 hours later. After the last one hour check was completed, the first 8 hour check was not completed until 20.25 hours later.

The HIR audit completed for the resident's fall did not indicate that the HIR was initiated 30 minutes after the resident's fall, that the HIR was not completed at the required time frames and that the dates were missing on the HIR form.

B) The resident had another unwitnessed fall. The HIR was initiated 30 minutes after the fall, not immediately. After the last one hour check was completed, the first 8 hour check was not completed until 8.75 hours later.

An 8 hour check was completed with no date indicated, the next 8 hour check was completed 10.5 hours later. The last 8 hour check did not include the date and time it was completed.

The HIR audit completed for the resident's fall did not indicate that the HIR was initiated 30 minutes after the resident's fall, that the HIR was not

completed at the required time frames, and that the date and time were missing on the last 8 hour check.

A Registered Nurse (RN) stated they had completed the HIR audit for the last fall the resident had. The RN stated that they did speak with staff about initiating the HIR late but did not include it on the audit as there was no column for that. The RN stated they thought that as long as the HIR was completed within an eight hour shift then it met the requirements of the audit. The RN did not realize the HIR was to be completed every eight hours.

Associate Director of Care (ADOC) #102 stated that an audit was to be completed for any resident with an unwitnessed fall to ensure all sections of the HIR form were completed for all three days.

The Director of Care (DOC) stated that the HIR should be initiated immediately post fall and should be completed at the required time intervals specified in the HIR form.

The DOC acknowledged that the HIR audits for the resident did not capture the errors in time intervals. The DOC acknowledged that the HIR audits did not check for accuracy as required by CO #004.

The DOC stated that staff had been focused on ensuring all components of the HIR were completed and that checking that the HIR was actually completed at the required time intervals was missed.

The HIR audits did not capture that the HIR was performed at the required time intervals and initiated immediately; therefore auditors missed that staff were inaccurately completing the HIR on residents. This placed the resident and other residents at risk as there would be a delay in detecting potential signs and symptoms of a head injury.

Sources: Review of the resident's HIRs, the home's HIR audits, the Home's HIR Monitoring form; and interviews with an RN, ADOC #102 and the DOC.

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #002

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 an order under s. 155 of the Act.

Compliance History: There is no compliance history related to FLTCA 2021, s. 104 (4).

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.

COMPLIANCE ORDER CO #001 Air Temperature

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure that,
A) Daily audits are completed to ensure the home's air temperature is at a minimum of 22 degrees Celsius, in the following on every home area: a common area and 3 resident bedrooms, ensuring different resident bedrooms are selected for each audit.
B) The audits are documented, indicating the date, home area, if any concerns were identified, and if any follow up action was required.

Grounds
The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius (C).

Rationale and Summary
During the inspection, a resident stated to an Inspector that they were cold. Maintenance Staff (MS) #107 completed a temperature check in the resident's room

with the Inspector. Air temperature in the resident's room was noted to be 22.7C at that time.

Review of the Daily Temperatures Log sheets for an 18 day time period, noted numerous common areas and resident rooms in different home areas were below 22 degrees C.

The Executive Director (ED) acknowledged that the air temperatures in these home areas were below 22 C.

There was risk to the residents not being comfortable when the air temperatures in the home were below 22 degrees Celsius.

Sources: Observations in the home; review of Daily Temperature Log sheets; and interviews with a resident, staff and management.

This order must be complied with by September 27, 2024

COMPLIANCE ORDER CO #002 Required Programs

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Reeducate all nursing staff on a specific home area on the requirements for completing and documenting Head Injury Routines (HIR). Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

B) Complete daily audits for a specific resident to ensure that HIR forms are completed and documented accurately for any falls that meet the criteria for HIR monitoring. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds
The licensee has failed to comply with the home's Falls Prevention and Management policy related to head injuries for a resident.

Rationale and Summary
In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure that they were complied with.

Specifically, registered staff did not comply with the licensee's Head Injury Routine (HIR) policy as part of the post-falls assessment.

Specifically, staff did not comply with the licensee's Head Injury Routine policy #VII-G-30.20, last reviewed March 2024, that was part of the licensee's Falls Prevention

and Management Program -which stated that a head injury routine would be initiated when a resident received an injury to the head, acquired a suspected injury to the head, or had an unwitnessed fall.

The home's HIR Monitoring form indicated that staff were to initiate a HIR for all unwitnessed falls and witnessed falls that resulted in a possible head injury. Staff were to monitor and document the resident's pulse, respirations, blood pressure, pupil reaction, level of consciousness, limb and/or involuntary body movement, evidence of nausea, vomiting, headache, change in mental status immediately at time of injury and as scheduled:

- Every (q) 30 minutes x 1 hours
- q 1 hours x 4 hours
- q 8 hours x 56 hours or until directed by the physician to cease monitoring.

Review of HIRs for a resident in the resident's hard copy chart noted the following:

1) A HIR was initiated for an unwitnessed fall. A HIR was to be completed at a specific time and instead 'sleeping' was documented for coma scale – eyes open, best verbal response, best motor response, pupils, limb movement and blood pressure.

2) A HIR was initiated for an unwitnessed fall. Documentation of the date and time for three checks were not completed as required.

A HIR was not completed at a specific time. Documentation under that time interval indicated that a HIR was reinitiated for a fall that occurred 1.25 hours after the HIR was to be completed.

3) A HIR was initiated for an unwitnessed fall. The date and time of the HIR checks were not documented on five occasions. One of the 8-hour checks was not completed until 2.25 hours later.

4) A HIR was initiated for an unwitnessed fall. There were no dates recorded, the time was illegible for a one-hour check and the first 8-hour check was completed four hours late, therefore the rest of the HIR checks were completed at incorrect times.

5) A HIR was initiated for an unwitnessed fall. There were no dates recorded on the resident's HIR form. The HIR was initiated 30 minutes after the fall, not immediately. The next 30 minute check was completed 1.5 hours later. After the last one hour check was completed, the first 8 hour check was not completed until 20.25 hours later.

6) A HIR was initiated for an unwitnessed fall. The HIR was initiated 30 minutes after the fall, not immediately. After the last one hour check was completed, the first 8 hour check was not completed until 8.75 hours later.

An 8 hour check was completed with no date indicated, the next 8 hour check was completed 10.5 hours later. The last 8 hour check did not include the date and time it was completed.

The Director of Care (DOC) acknowledged that the HIR was not completed in full at all the interval times required, as per the home’s Head Injury Policy.

There was risk to the resident when they were not neurologically assessed for changes in their level of consciousness or responsiveness for several of the required time periods.

Sources: Review of clinical records for the resident, Head Injury Routine policy #VII-G-30.20, last reviewed March 2024; and an interview with the DOC.

This order must be complied with by

September 27, 2024

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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

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.