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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 8, 2024	
Inspection Number: 2024-1329-0001	
Inspection Type: Complaint 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: The Meadows, Ancaster	
Lead Inspector Stephanie Smith (740738)	**Inspector Digital Signature** Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2024.02.13 09:21:15 -05'00'
Additional Inspector(s) Kerry O'Connor (000769)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 25-26, 29-31, February 1-2, and 5, 2024.

The following intake(s) were inspected:

- Intake: #00095747 - Critical Incident (CI) 2844-000023-23 - Related to an outbreak.
- Intake: #00104129 - CI 2844-000026-23 - Improper/Incompetent treatment of a resident by staff.
- Intake: #00104240 - Complaint related to plan of care.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident was being monitored for pain and new skin impairments. Personal Support Workers (PSWs) were responsible for documenting any identified pain or new skin impairments.

The resident's records indicated missing documentation of this monitoring for five night shifts in December, 2023.

The Director of Care (DOC) confirmed that the expectation was for staff to complete their documentation and acknowledged it was not completed for those dates.

Failure to ensure that monitoring of the resident's pain and skin were documented had potential to not identify pain or new skin impairments.

Sources: Resident's clinical record, interview with DOC. [740738]

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit, and implement a plan to ensure residents are protected from neglect, specifically that staff provide care with two persons when specified in the resident's care plan.

The plan shall include but is not limited to:

- The type of re-training involved, including who will be responsible for the re-training and when it will be completed;

- The person responsible for monitoring that residents are provided care with two persons when specified in their care plans, as well as a timeline for how long the monitoring will occur;
- The person responsible for implementing an action plan if monitoring demonstrates a resident's care plan is not complied with; and
- Actions to address sustainability once the home has been successful in ensuring compliance with resident care plans.

Please submit the written plan for achieving compliance for inspection 2024-1329-0001 to Stephanie Smith (740738), LTC Homes Inspector, MLTC, by email to HamiltonDistrict.MLTC@ontario.ca by February 23, 2024. Please ensure that the submitted written plan does not contain any Personal Information (PI)/Personal Health Information (PHI).

Grounds

The licensee has failed to protect a resident from neglect by staff.

Section 2 of Ontario Regulation (O. Reg.) 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

On a specified date in December, 2023, a resident was receiving assistance from a staff. The resident's care plan at the time indicated that they required two person assistance.

As indicated in the home's submitted CI, as well as confirmed via interviews, the staff provided care to the resident without the aid of another staff. As a result, the resident fell out of the bed and sustained injuries.

The home's investigation determined that the staff provided care to the resident alone and did not wait for assistance from another staff. The staff failed to provide the resident with the assistance required for safety and jeopardized the resident's safety when they performed care alone.

Failure to protect a resident from neglect by a staff led to significant harm.

Sources: Resident's clinical record, the home's investigation notes, CI: 2844-000026-23, interviews with staff. [740738]

This order must be complied with by March 8, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

- Educate all staff on Fieldcote Lane including staff delivering supplies to the unit, on the proper use of personal protective equipment (PPE), including appropriate selection, application, removal and disposal.

- Document the education including the date and the staff member who provided the education and staff signatures of completion.
- Perform twice weekly audits for a period of four weeks. Audits to be initiated after the education has been completed and should include audits of routine and additional precautions: if an outbreak occurs during this time the outbreak area must be included in the audits.

Grounds

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, was implemented.

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (d) proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary

On a specified date in January, 2024, a staff member was observed exiting an outbreak unit, wearing a face shield and an N95 mask. The staff member did not remove their face shield and N95 mask and reapply new PPE. The staff member returned a few minutes later, performed hand hygiene and entered the outbreak area. The face shield and mask were not changed.

On a specified date in January, 2024, a staff member was observed outside the doors of an outbreak unit. The staff member completed hand hygiene and applied a face shield prior to entering into the unit. An N95 mask was not applied.

On a specified date in February, 2024, two staff members were observed in a dining area on an outbreak unit. The staff members working within the area wore yellow isolation gowns, gloves, surgical masks and face shields. Upon staff recognizing

inspector's arrival, one staff member asked the charge nurse for two N95 masks and both staff members changed from surgical masks to N95 masks.

The IPAC lead advised that staff entering an outbreak area should apply an N95 mask. Staff upon exit from the outbreak area are required to remove face shields and N95 mask, perform hand hygiene, and apply new face shield and surgical mask (or N95 mask if going into an outbreak unit).

Staff working within the dining area were required to wear an N95 mask and should not have been wearing surgical masks.

Failure of staff not applying appropriate PPE when working in an outbreak area increased the risk of spreading infection to residents and staff.

Sources: Observations, interview with IPAC lead. [000769]

This order must be complied with by March 29, 2024

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.