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
hamiltondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: February 2, 2023	
Inspection Number: 2022-1347-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Northridge, Oakville	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2023.02.06 15:31:03 -05'00'
Additional Inspector(s) Parminder Ghuman (706988) Sydney Withers (740735)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 6, 2022-December 9, 2022, December 12, 2022- December 16, 2022, December 19, 2022-December 22, 2022.

The following intake(s) were inspected:

- Intake: #00002640- Complainant with concerns re resident related decline in health.
- Intake: #00006880- [CI: 2862-000006-22] Alleged staff to resident neglect.
- Intake: #00012146- [CI: 2862-000037-22] Physical abuse to resident by staff.
- Intake: #00012306- Complainant with concerns regarding resident's pain management and allegations of retaliation.
- Intake: #00012359- [CI: 2862-000038-22] - Neglect of resident by staff.
- Intake: #00013092- [CI: 2862-000043-22] - Abuse / Neglect of resident by staff. Concerns re: rough handling of resident and pain management.

Intake: #00014773-IL-07788-AH/ [CI: 2862-000052-22] - Improper / incompetent care of resident by staff.

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

Resident Care and Support Services
Infection Prevention and Control
Skin and Wound Prevention and Management
Pain Management
Prevention of Abuse and Neglect
Medication 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)

Rationale and Summary

The licensee failed to ensure that a resident's plan of care which included staff to provide supervision and monitoring to ensure that resident is safe in their surroundings, including toilet use as resident has been assessed with significant risk for a fall related injury.

A Resident's care plan indicates to have 1:1. A video evidence reviewed by inspectors on March 5, 2022, found resident to self transfer and walk in room. Personal Support Worker (PSW) went to assist the resident and did not find 1:1 staff in the room. According to the home's investigation notes and an interview with Registered Practical Nurse (RPN), they stated that they were aware of the care plan, but care plan was not followed for the resident. Interviews with Director of Care (DOC) and Executive Director (ED) and review of the plan of care confirmed that staff failed to follow the resident's plan of care for falls prevention by not having the 1:1 staff to provide supervision and monitoring to ensure that resident was safe in their surroundings.

Not having the 1:1 staff to provide supervision and monitoring to ensure that resident is safe in

their surroundings poses a risk for a fall related injury.

Sources: Resident #002's plan of care, the home's investigation notes, 1:1 monitoring notes, Video 01, and interviews with PSW #102, RPN #104, DOC #115 and ED #101.

[706988]

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the care set out in resident's plan of care was documented.

Rationale and Summary

A resident's Care Plan and Kardex were reviewed, and it was noted that the resident requires repositioning in bed every two hours. A review of available tasks in Point of Care (POC) and the completed tasks in the Documentation Survey Report respectively indicated no repositioning task was available or documented.

An interview with an RPN confirmed that repositioning every two hours was one of the wound care-related tasks to be completed for resident by PSWs.

PSW stated that the task for repositioning resident every two hours was not present in POC; however, it was completed for this resident.

The Resident Assessment Instrument (RAI) Coordinator and the DOC agreed that the completion of this task was not documented within resident's plan of care.

The absence of a task listed in POC to document repositioning resident may have led to the task not being completed at the required frequency, risking worsening of the coccyx wound.

Sources
Resident #001's Care Plan; Kardex; POC; Documentation Survey Reports (June-August 2022);

interviews with RPN #112, PSW #102, RAI Coordinator and DOC.

[740735]

WRITTEN NOTIFICATION: Improper use and access to Personal Protective Equipment in Droplet Precautions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that standard issued by the director with respect to the Infection Prevention and Control (IPAC) Standard was Implemented.

Rationale and Summary
According to O. Reg. 242/22, s.102 (2) (b), the licensee was required to implement any standard or protocol issued by the director with respect to IPAC.
The homes IPAC program outlined and displayed across the unit appropriate Personal protective equipment (PPE) required, and eye protection was required to be worn while on Coronavirus Disease 2019 (Covid-19) outbreak.

On December 6, 2022, at 12:26 pm, staff was serving food in dining room with no eye protection on a confirmed Covid Outbreak unit.

On December 6, 2022, at 2:53 pm, staff entered a Covid positive resident's room wearing an N95 mask and face shield only to administer medication. At 3:00pm staff # 104 exited the resident's room without removing mask and without changing or cleaning eye protection.

On December 6, 2022, at 3:20 pm, staff was giving report in the dining room with mask but no eye protection on a Covid outbreak unit.

On December 8, 2022, at 12:00 pm, five staff were serving residents with no eye protection in the dining room. RN was providing medication in the dining room without eye protection.

The entire home was in Covid-19 Outbreak and all units had active Covid cases and had not been cleared out of outbreak at the time of the observation. All three staff confirmed that they should have been wearing eye protection. The fourth staff confirmed that they should have worn a gown and gloves when entering resident's room, as well as changing gown and cleaning or changing eye protection.

There is a risk of harm to residents acquiring infection as staff are not using proper PPE as observed at the point of care.

Sources:
Infection Control Policy – IPAC standard and routine practice
Observation and Interview of PSW # 104,106,107,108
Interview with IPAC Manager

[741771]