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: December 8, 2023	
Inspection Number: 2023-1334-0003	
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: Ridgeview, Stoney Creek	
Lead Inspector Erin Denton-O'Neill (740861)	**Inspector Digital Signature** Erin Denton-O`Neill Digitally signed by Erin Denton-O`Neill Date: 2023.12.20 15:21:49 -05'00'
Additional Inspector(s) None	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25 - 27, 30, 31, 2023 and November 1 - 3, 7, 21, 23, 2023.

The following intake(s) were inspected:

- Intake: #00001892 - Critical incident (CI) related to resident-to-resident physical abuse
- Intake: #00003497 - CI related to physical abuse to a resident by staff
- Intake: #00005719 - CI related to an unexpected death of a resident
- Intake: #00086390 - CI related to an unexpected death of a resident.
- Intake: #00093548 - CI– related to falls prevention

The following intakes were completed in this inspection:

- Intake: #00098496 - CI– related to falls prevention

- Intake: #00087055 - CI - related to falls prevention

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

Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting resident abuse to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that alleged abuse was reported immediately to the Director.

Rationale and Summary

An agency staff allegedly witnessed an agency PSW giving a resident medication to control the resident's responsive behaviours. The agency staff had been educated on prevention of abuse and the duty to report alleged abuse immediately to the director but did not report immediately. This incident was not reported to the Director until four days later. Staff #111 confirmed that the agency staff were educated prior to working with residents and that it was the expectation that agency staff and agency providers report allegations of abuse immediately.

Sources: CI, internal investigation notes and emails, internal HR records, interview with DOC #111

[740861]

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

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

- Provide access every shift to all 1:1 supplementary staff including agency staff, a current resident care plan.
- Perform weekly audits for three weeks or until compliance is achieved on all 1:1 assignments to ensure all 1:1 staff have access to current care plans for the resident that they are working with and document the actions based on audit results.
- Provide education to all RN's and RPN's related to the requirement to give a full report to all 1:1 supplementary staff, agency or otherwise at the start of every shift.
- Provide education to all 1:1 supplementary staff on the need to implement all strategies in the resident's care plan related to prevention of responsive behaviours.

Grounds

The licensee has failed to ensure that interventions to minimize the risk of altercations and potentially harmful interactions among residents were not implemented.

Rationale and Summary

A resident who had a history of responsive behaviours, pushed another resident causing them to fall and sustain an injury. The internal investigation notes indicated that interventions in the care plan had not been implemented to prevent the resident from being responsive. Staff #111 confirmed that the incident occurred and that they reported it to the Director. DOC #110 confirmed that it is the expectation that the staff would have followed a resident's plan of care implementing strategies to prevent altercations between residents.

Sources: CI, resident #005 and #006 progress notes, resident #006 care plan, interviews with previous and current DOC.

[740861]

This order must be complied with by January 19, 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

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.