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
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Original Public Report

Report Issue Date: May 14, 2024	
Inspection Number: 2024-1334-0002	
Inspection Type: Proactive Compliance Inspection	
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 Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2024.05.27 09:58:47 -04'00'
Additional Inspector(s) Betty Jean Hendricken (740884)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2-3, 6-10, 2024

The following intake was completed during this inspection:

- Intake: #00114934 - Proactive Compliance Inspection

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management

Pain Management
Prevention of Abuse and Neglect
Quality Improvement
Resident Care and Support Services
Residents' and Family Councils
Residents' Rights and Choices
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

On a resident home area, near resident rooms, several tools in a tool pouch and open backpack, including screws, screw drivers and pliers, were observed on a cart and left unattended. The Environmental Services Manager (ESM) stated that electricians were working throughout the home and that they were given extensive instruction regarding not leaving tools and other equipment unattended in the resident home areas.

The ESM spoke with the electricians and reminded them to not leave their tools unattended. A follow up observation determined that the cart with tools was no longer in the hallway and unattended.

Sources: observations and interview with the ESM. [720920]

Date Remedy Implemented: May 6, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents, could not be opened more than 15 centimetres (cm).

During an initial tour of the home, a window with an opening of 20 cm was observed. The ESM confirmed that the window restrictor was in place but that the window opened 20cm.

The ESM immediately repaired the restrictor on the window. The window opening was re-checked, and the measurement was within regulations.

Sources: observations; interview with staff. [740884]

Date Remedy Implemented: May 2, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (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 IPAC Standard for Long-Term Care Homes section 9.1 (e) specified that the licensee shall ensure that Additional Precautions are followed in the IPAC program and at minimum, additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

The Executive Director (ED) explained that while a resident home area remained in outbreak, all of the residents were out of isolation. Observations showed that three resident rooms had droplet/contact +N95 additional precautions signage on the doors. A personal support worker (PSW) reported that the residents were no longer in isolation and that the signs had not yet been removed. A registered nurse (RN) verified that no resident on the home area was in isolation, however, they explained that one resident's additional precautions signage should have been changed, rather than removed, while they waited on confirmation of test results.

Follow-up observations showed that the additional precaution sign on one resident's was changed and the signs for the other two residents were removed.

The former IPAC Lead/ADOC acknowledged that when residents no longer required additional precautions or the level of additional precautions changed, the signage should be removed and/or changed immediately.

Sources: observations; IPAC Standard for Long-Term Care Homes (revised September 2023); interview with the former IPAC Lead/ADOC and other staff. [720920]

Date Remedy Implemented: May 3, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The home was required to create and publish a Quality Improvement (QI) report. The report was to identify actions to improve accommodation, care, services, programs and goods provided to the residents in the home's priority areas for quality improvement, including the dates the actions were implemented.

A review of the home's QI report, published on their website, did not include dates that actions would be implement related to the identified priority areas. The ED acknowledged that the dates were not included in the published report. The report was updated with the missing information.

Sources: QI Report (April 2, 2024); interview with the ED. [720920]

Date Remedy Implemented: May 10, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iv.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

The home's continuous quality improvement committee (CQI) were required to be involved in the actions taken to improve the home based on both the results of resident and family/caregiver experience surveys, and identified priority areas. The role the CQI committee took was to be included in their QI report.

A review of the home's QI report, published on their website, did not include the role of the CQI committee. The ED acknowledged that the published report did not contain that information. The report was updated with the missing information.

Sources: QI Report (April 2, 2024); interview with the ED. [720920]

Date Remedy Implemented: May 10, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings from the Chief Medical Officer of Health, specified that alcohol based hand rub (ABHR) must not be expired.

An expired bottle of ABHR was observed in the servery of a resident home area. The expiry date was shown to a dietary aide who then removed the bottle and said they would get a new one from the housekeeper. During a follow up observation, no expired bottles of ABHR were found in the dining room or servery on that resident home area.

The former IPAC Lead/ADOC acknowledged that expired ABHR may not have the required 70-90% alcohol content, as the expiry dates of ABHR ensures the product's efficacy.

Sources: observations; Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (Ministry of Health, April 2024); interview with the former IPAC Lead and other staff. [720920]

Date Remedy Implemented: May 3, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #007 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 related to fluid consistency.

Rational and Summary
A resident's fluid consistency was changed. Their clinical records, and meal service report were all updated to reflect that the resident was to receive thickened fluids.

During meal service, the resident was provided orange sorbet. The Dietary Manager (DM) explained that any resident requiring thickened fluids would receive pudding or mousse for dessert in place of ice cream, sherbet or sorbet. The home's thickened fluids guidelines specified that foods such as ice cream, sherbet, frozen yogurt, etc., would become liquid in the mouth and was not recommend for those residents requiring thickened fluids. The document also included that those foods should only be provided after an assessment and approval by the Registered Dietitian (RD).

A review of the dietary referrals showed that the only referral sent during that time was the one indicating the fluid consistency change. The RD verified that they had not assessed the resident to determine their ability to safely consume frozen desserts. They stated that the resident was to receive thickened fluids and should

not have received orange sorbet.

Failure to provide food/fluids that were appropriate for the resident had the potential for the resident to aspirate, which could have resulted in pneumonia.

Sources: observations; resident's clinical records, Therapeutic Diets and Fluid/Texture Modification (CARE7-O10.06, March 31, 2024), Guidelines for Thickened Fluids (October 2020); and interviews with the DM and RD. [720920]