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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 23, 2023
Inspection Number: 2023-1348-0002
Inspection Type: Critical Incident System
Licensee: AXR Operating (National) LP, by its general partners
Long Term Care Home and City: Stirling Heights, Cambridge

Lead Inspector	**Inspector Digital Signature**
Tracey Delisle (741863)	Tracey DeLisle Digitally signed by Tracey DeLisle Date: 2023.02.27 13:05:02 -05'00'

Additional Inspector(s)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 26 - 27, February 3, 6 - 8, 13 - 14, 2023

The following intake(s) were inspected:

- Intake: #00005896 - [Critical Incident: 2863-000014-22] Fall resulting in a transfer to hospital and injury
- Intake: #00006202 - [Critical Incident: 2863-000009-22] Responsive behaviours resulting in a fall, transfer to hospital and injury.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #001 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 the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC, specifically as it relates to the IPAC Standard - Additional Requirement 9.1 for Additional Precautions shall include (f) Additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

Rationale and Summary
During inspection, it was observed that the signage and available PPE for contact/droplet precautions was posted outside two resident rooms. A staff member was assisting one resident with lunch and wearing all the proper PPE as per the precautions, then proceeded to another resident in the adjoining room without doffing and donning new PPE before assisting them with lunch. The staff member wore all the same PPE, including gown, gloves, and face shield to care for both residents and confirmed in an interview that the PPE was not donned and doffed between residents and stated they were not trained to do anything different.

It was confirmed in the plan of care that both residents were placed on contact/droplet precautions for different symptoms of infection.

Management confirmed that all PPE should be donned and doffed between all residents that require PPE for any precautions due to infection.

By not donning and doffing PPE as required, the staff member could have spread harmful bacteria or viruses between the two residents.

Sources: IPAC Standards, (last revised April 2022), resident's clinical records, Interview with staff and management, observation of residents and their rooms, observation of staff in rooms of both residents.

[741863]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that resident #001's plan of care was reviewed and revised when their care needs related to falls prevention and management changed after being assessed at a high falls risk.

Rationale and Summary
A resident was identified to be a high risk for falls. No falls prevention and management interventions were included in their plan of care until after they sustained an injury.

Failure to ensure that resident's plan of care was reviewed and revised could have resulted in staff being unaware of resident's falls interventions, which put them at risk for injury.

Sources: Interview with staff, Resident's clinic records, Falls Risk Screen V2.

[740884]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident plan of care provided clear directions to staff and others who provide direct care related to bed height for transfer support.

Rationale and Summary
The Resident's care plan was reviewed at the time of inspection and documented their bed height should be kept in the lowest possible position. It also documented that the bed height should be kept at appropriate height so their feet could rest on the floor. An interview with staff confirmed a discrepancy in interventions for bed height related to transfer support.

Failure to ensure the plan of care provided clear directions to staff and others who provide direct care related to bed height for transfer support, put the resident at risk of injury.

Sources: Interview with staff, Resident's clinic records, observation of resident.

[740884]