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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 6, 2023

Inspection Number: 2023-1168-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: AXR Operating (National) LP, by its general partners

Long Term Care Home and City: Elmwood Place, London

Lead Inspector	**Inspector Digital Signature**
Rhonda Kukoly (213)	Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2023.04.13 14:01:09 -04'00'

Additional Inspector(s)
Peter Hannaberg (721821)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 22, 23, 24, 27, 28, 29, 2023, and offsite on March 30, 2023.

The following intake(s) were inspected:
- Intake #00003014, Critical Incident #3054-000031-22, related to a fall
- Intake #00011583, Critical Incident #3054-000033-22, related to a fall
- Intake #00015272, Critical Incident #3054-000034-22, related to care concerns
- Intake #00016778, Critical Incident #3054-000036-22, related to an unexpected death
- Intake #00019161, a complaint related to care concerns
- Intake #00083826, a complaint related to care concerns

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: When reassessment, revision is required

NC #001 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 a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care related to multiple care concerns for a resident.

The resident's health records, observations and interviews throughout the course of the inspection showed conflicts between direction in the care plan and plan of care, documentation of care, the observed care, what the staff said the resident required and what they were providing, in several care areas including transfers, mobility/ambulation, bed mobility, continence, falls prevention, oral care, and responsive behaviours.

The Director of Care said the plan of care was not up to date, not consistent and didn't make sense. They said that new direction was added without completing assessments and without removing old direction to ensure it was consistent and appropriately based on an assessment. The expectation was that if there was a change in condition, there should have been assessments completed, and that the care plan as a whole, needed to be reviewed and revised.

There was risk that the resident did not receive the care they required, also creating a risk for harm, when they were not reassessed and the care plan not revised, when the resident's care needs in multiple care areas changed.

Sources: Health records for a resident, observations of a resident, and staff interviews. [213]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plans of care for two residents was based on assessment of the residents' needs and preferences.

Rationale and Summary
Complaints were received by the Ministry of Long-Term Care related to multiple care concerns for two residents.

A) When a resident was admitted to the home, their Substitute Decision-Maker (SDM) notified the registered nursing staff of a potential problem. The registered staff said they would follow up. There was no documentation to show that this was completed.

The Director of Care (DOC) said that the home was made aware of the resident's need for assessment of the potential problem and that it was not completed. After a significant change in condition, the potential problem was confirmed requiring treatment.

B) A resident had weight loss recorded over three months. One of the strategies to manage the weight loss was to provide the resident with an oral nutritional supplement which was available in a specific flavour. The resident's care plan indicated they preferred flavours other than the one provided in the ordered supplement.

Registered nursing staff were observed providing the resident with a different type of supplement than had been assessed as most appropriate by the Registered Dietitian (RD) and ordered by the resident's physician. The resident consumed the full amount of supplement provided. The staff said that they understood there was a difference in the nutritional qualities of the supplement; however, the resident tended to prefer the flavour of the different type than the one that was ordered. They said they had not discussed this preference further with the care team, including the RD who was responsible for assessing weight management interventions.

The DOC said that the resident needed to be reassessed and the care plan reviewed by the interdisciplinary team with the family, to ensure it was based on the needs and preferences of the resident. There was a risk to the resident that they would not receive adequate nutritional support to manage their weight loss when a different supplement was provided than the product which was assessed and recommended by the RD.

Sources: Health records for two residents, observations of a resident, and staff interviews. [721821]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care with concerns regarding positioning for a resident.

The plan of care for a resident included a specific intervention related to positioning. On three different days, the resident's care was observed not being provided as specified in the care plan. Staff said they were aware of the direction in the plan of care, but that they could not do that for specific reasons. The Director of Care said that the expectation was for staff to provide the care as specified in the plan, and if this was not possible, the plan of care needed to be reviewed with assessment and interdisciplinary discussion.

There was risk of harm to the resident when the care was not provided as specified in the plan of care.

Sources: Health records for a resident, observations of the resident, and staff interviews. [213]

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to provide bathing care to a resident at minimum twice per week.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care related to multiple care concerns for a resident including a lack of bathing and nail care.

There was no documentation over a period of nine days, that bathing care was provided. Staff said that bathing care would be documented, and the resident's initials would be included on the Bath/Shower Water Temperature Log when bathing care was provided. Three staff members said that they worked during that time period, and they could not recall a bath being provided to the resident. The Director of Care (DOC) and the Assistant DOC said that no evidence could be found that bathing care was provided to the resident during that time period, and that it should have been provided.

Sources: Health records for a resident, Bath/Shower Water Temperature Log and staff interviews. [721821]

WRITTEN NOTIFICATION: Foot care and nail care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)

The licensee has failed to provide a resident with fingernail care including the cutting of fingernails.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care related to multiple care concerns for a resident, including a lack of bathing and nail care.

The home's policy titled "LTC - Bath and Shower Guidelines, last modified date: February 9, 2022", stated that resident nail care was to be performed as part of the bathing care according to the resident's individual needs and preferences.

There was no documentation that showed bathing or nail care was provided to the resident over a nine day period of time. Staff said that bathing and nail care would be documented and the resident's initials would be included on the Bath/Shower Water Temperature Log when bathing care was provided. Three staff each stated that they worked the week that the resident was in the home on their home area, and they could not recall a bath or nail care being provided to the resident. The Director of Care (DOC) and the Assistant DOC stated that no evidence could be found that nail care was provided to the resident

while they were in the home, and that it should have been.

Sources: Health records for a resident, Bath/Shower Water Temperature Log and staff interviews. [721821]

WRITTEN NOTIFICATION: When licensee shall discharge

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 158 (4) (a)

The licensee has failed to ensure that a resident was discharged from the home when the resident was on a medical leave which exceeded thirty days.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care related to multiple care concerns for a resident.

A resident was transferred to hospital with multiple health-related concerns. While the resident was in hospital, a representative from Home Care and Community Support Services (HCCSS) called the Director of Care (DOC) and requested a 17 day extension of the thirty-day medical leave. The DOC said that they agreed to this extension. The Resident Services Coordinator/Acting Administrator (RSC/AA) and the resident's progress notes said the resident's bed remained unoccupied at the home in anticipation of the resident's return from hospital for 35 days beyond the regulated 30-day medical leave.

Sources: Health records for a resident, staff interviews, and interview with HCCSS Manager [721821]