Original Public Report

Report Issue Date August 11, 2022
Inspection Number 2022-1593-0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
AXR Operating (National) LP

Long-Term Care Home and City
West Oak Village, Oakville

Lead Inspector
Barbara Grohmann (720920)

Additional Inspector(s)
Daria Trzos (561)

Inspector Digital Signature
Barbara Grohmann
2022.08.25 15:38:56 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 19-22, 25-29, 2022.

The following intake(s) were inspected:

- Intake # 01090-22 (CI #2870-000016-22) related to alleged sexual abuse.
- Intake # 005840-22 (complaint) related to resident care, personal belongings, and hot water boilers/tanks.

- Intake # 002903-22 (Follow-up) related to Infection Prevention and Control (IPAC).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229 (4)	2022-943988-0004	#001	Barbara Grohmann (720920)

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 3(1)18

In a resident home area, signs were observed next to the rooms for nine residents. The signs depicted red or yellow triangles with white exclamation points with the wording COVID positive or Symptomatic and Full PPE (personal protective equipment) underneath. Those residents had either tested positive by rapid antigen testing, or were symptomatic, and the home was awaiting polymerase chain reaction (PCR) tests results as confirmation.

Interim director of care (DOC) explained that the signs were posted based on the direction from Revera via their COVID Playbook and acknowledged that they disclosed residents' medical information.

The previous signs were replaced with one that included the colour coding and symbol but not the written information.

Sources: observations; Revera COVID Playbook and signage; interview with interim DOC.

Date Remedy Implemented: July 22, 2022 [720920]

WRITTEN NOTIFICATION – RESIDENTS' BILL OF RIGHTS

NC#02Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3(19)ii

The licensee has failed to ensure that a resident had the right to give or refuse consent to treatment.

Rationale and Summary

The plan of care for a resident indicated that the resident had moderate impairment; however, they were able to understand what treatment was being provided to them. They had the capacity to consent and refuse treatment. The physician had written an order to obtain a sample. A registered staff decided to perform the procedure to obtain a sample from the resident. The staff stated that initially the resident did not consent to the procedure but then they nodded, therefore, they assumed the resident had consented. The investigation notes indicated that once the procedure began the resident yelled. The registered staff did not stop the procedure. As a result, this led the resident to feel uncomfortable. Days later, the resident reported to another registered staff that they were assaulted.

When the staff member did not respect the resident's right to refuse treatment, a procedure was performed which made the resident feel uncomfortable and distressed.

Sources: investigation notes; resident's plan of care; policy "LTC-Informed Consent to Treatment" (February 9, 2022); interviews with staff and ED. [561]

WRITTEN NOTIFICATION – PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 6(1)(c) under the Long-Term Care Homes Act, 2007 and s. 6(1)(c) under the Fixing Long-Term Care Act, 2021.

The licensee has failed to ensure that a resident's plan of care provided clear directions to staff and others who provided direct care to the resident, specifically the care and storage of their denture.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6(1)(c) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6(1)(c) of FLTCA.

Rationale and Summary

The home was alerted that a resident's denture was missing. The denture was replaced, and the home initiated a process to monitor the denture to reduce the risk of them being misplaced in the future.

At that time, the resident's care plan stated the following:

i) In the oral hygiene focus, the resident had denture that was to be soaked overnight and brushed with toothpaste in the morning.

ii) In the eating and swallowing focus, the nurse was to collect the denture at night, store them in the med-cart and apply in the morning. Also, the denture was to be cleaned with water and a toothbrush and not toothpaste.

The resident's plan of care included the following tasks created, to monitor the denture:

i) Nurse to remove the upper denture at night, store in the med-cart and the PSW to clean with water and toothbrush (not to use toothpaste for cleaning).
ii) Nurse to apply upper denture in the morning.

Months later, the denture was given to the resident in the morning and not retrieved in the evening. A PSW explained that they, not the nurses, were responsible for documenting whether the tasks were completed. They also confirmed that the resident was not wearing the denture at the time of the inspection and had not been for a while.

The executive director (ED) stated that they had expected the nurses would be the ones to sign off on the collection and administration of the dentures.

Failure to provide clear direction in the plan of care may have resulted in staff being unaware of how to care/store resident's denture, leading to it being misplaced.

Sources: observations**,** resident's clinical records; interviews with ED and other staff**.** [720920]

WRITTEN NOTIFICATION – SAFE AND SECURE HOME

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24(3)

The licensee has failed to ensure that air temperatures outlined in subsection (2) were documented once every morning, once every afternoon between 12 and 5 pm and once every evening or night.

Rationale and Summary

O. Reg. 246/22 s. 24(2), stated that air temperatures were to be measured and documented in writing in the following areas of the home:

1) At least two resident bedrooms in different parts of the home.
2) One resident common area on every floor of the home.
3) Every designated cooling area, if there are any in the home.

Temperature recording logs for May 1 to 31, 2022, indicated that air temperatures were not documented four mornings, five afternoons and 18 evenings.

An RPN acknowledged that the nursing staff were to take the air temperatures and record them in the home's temperature log. The ED explained that the nursing staff were to document the air temperatures as per ministry requirements.

Failure to record air temperatures as per ministry requirements may have prevented the home from knowing when to initiate their heat related illness plan.

Sources: temperature logs; interviews with ED and other staff. [720920]

WRITTEN NOTIFICATION – GENERAL REQUIREMENTS FOR PROGRAMS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 34(2)

The licensee has failed to ensure that the procedure and resident's response to the procedure was documented.

Rationale and Summary

A registered staff performed a procedure to obtain a sample for a resident. There was no documentation indicating that the procedure was performed and the resident's response, if any. The registered staff confirmed that they failed to document that they had performed the procedure. The home's policy titled "LTC-Interdisciplinary Documentation", indicated that documentation in the interdisciplinary progress notes should occur when any changes or differences are noted in the residents' care or condition. ED confirmed that the staff should have documented the procedure in progress notes.

Sources: resident's progress notes; policy "LTC-Interdisciplinary Documentation" (reviewed date March 31, 2022); investigation notes; interviews with staff and ED. [561]

COMPLIANCE ORDER [CO#001] – PLAN OF CARE

NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: FLTCA, 2021 s. 6(7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Plan [*FLTCA, 2021, s. 155 (1) (a)*]

Specifically, the licensee shall ensure that the following are met:

1. Three registered staff members shall receive education on the home's process for reviewing and actioning physician orders specific to a procedure.
The home shall keep a record of the contents of the education, who provided the education, the date the education was provided and a sign of sheet that three registered staff members completed the education.

2. Ensure the resident receives a caregiver as per their plan of care by completing daily audits to ensure the resident's plan of care is followed for a two-week period following the compliance due date. A copy of the audits must be kept in the home that is accurate and complete.

Grounds

Non-compliance with: FLTCA, 2021 s. 6(7)

A) The licensee has failed to ensure that the physician's order related to obtaining a sample was followed for a resident.

Rationale and Summary
The physician had written an order for staff to obtain a sample from a resident, that included specific instructions on how the sample was to be collected. Registered staff on the following two shifts did not obtain a sample as indicated in the physician order. A registered staff did not attempt to collect the sample as per the physician's instructions. A few days later, the resident alleged the procedure performed to obtain the sample made them uncomfortable and an investigation was completed by the home. It was determined that the registered staff did not follow the physician's order and did not attempt to collect the sample using the least invasive procedure.

Failing to follow the physician's order related to obtaining a sample, led to the invasive procedure which caused the resident to become distressed.

Sources: review of investigation notes including disciplinary letter; resident's plan of care; interviews with staff and ED. [561]

B) The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident.

Rationale and Summary
The plan of care for a resident stated specific criteria regarding caregivers for all personal care. On a specific day, a registered staff performed a procedure to collect a sample on the resident which led to the resident alleging they were assaulted. The registered staff and the PSW who assisted them during the procedure stated that they were not familiar with this unit

and did not review the plan of care for the resident. ED stated that their investigation concluded the RPN should have reviewed the plan of care for the resident and should not have performed this procedure.

Failing to follow the plan of care for the resident, and proceeding with an invasive procedure, caused the resident to be in distress.

Sources: Resident's plan of care; review of investigation notes; interviews with staff and ED. [561]

This order must be complied with by September 23, 2022

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

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
email: 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.