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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 15, 2024
Original Report Issue Date: January 4, 2024
Inspection Number: 2023-1355-0008 (A1)
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: West Oak Village, Oakville

Amended By Stacey Sullo (000750)	**Inspector who Amended Digital Signature** Stacey Sullo Digitally signed by Stacey Sullo Date: 2024.01.16 15:49:28 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Update CO #001 to include the word “month” in the order for audits to be completed by the LTCH.

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Lead Inspector Stacey Sullo (000750)	**Additional Inspector(s)** Jennifer Bertolin (740915)
Amended By Stacey Sullo (000750)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4, 5, 6, 7, 2023.

The following intake(s) were inspected:

- Intake: #00022122 - IL-10839-AH/2870-000010-23 - Improper/incompetent care of resident.
- Intake: #00084709 - 2870-000012-23 - Allegation of physical abuse of resident by staff.
- Intake: #00086449 - IL-12499-AH/2870-000016-23/2870-000017-23 - Allegation of neglect of resident by staff.
- Intake: #00089006 - 2870-000024-23 - Improper/Incompetent treatment of resident by staff.
- Intake: #00095872 - 2870-000046-23 - Allegation of neglect of resident by staff.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146 (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Rationale and Summary:
Resident's care plan stated resident required monitoring after receiving medication.

During staff interview who confirmed nursing staff never completed a follow up assessment on resident after administering medication.

There was a risk to resident when staff failed to monitor the residents response and effectiveness of the medication administered.

Sources:
Record review of resident's Plan of Care, Kardex, Electronic medication administration record, Follow up Electronic medication administration, staff interviews, and observations of resident.

[000750]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. Retrain Personal Support Worker (PSW) and Registered Nurse (RN) involved in Critical Incident, on the prevention of neglect and abuse policy, and resident's bill of rights.
2. Administrative staff will create a written process that will include a written sign off tool to be used by PSW's, and RN's on all units during the night shift for the purpose of night staff reporting off to one another prior to leaving the unit for breaks. Administration will then educate all PSW's, and RN's who work night shift on the sign off reporting tool. Once the staff have received the training they will sign and date that the education has been provided to them, and a copy of the sign off tool will be recorded and kept on site.
3. Administration will audit the sign off sheets for the night shift on all units daily for one month, then three days a week for one month on each shift for each unit, then once a week for one month on each unit and will keep a record of all audits and any deficiencies found, along with any corrective actions taken.

Rationale and Summary:

Resident was identified as a fall risk during a fall risk assessment. The intervention listed were to have staff complete hourly safety checks.

The definition of Neglect, as defined in the O. Reg 246/22 s. 7. means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Personal Support Worker (PSW) was assigned to work a shift on a unit. During the shift the PSW left the unit and Long Term Care Home (LTCH) while on break, never informed any of the other staff working that they were leaving the unit. The PSW did not return to the LTCH to complete the rest of their shift.

During interviews with staff it was confirmed that a PSW was assigned to work on the unit, however the PSW left the LTCH without reporting their absence to any other staff members and never returned to the LTCH to finish their shift.

Staff confirmed who were working the next shift that they never received report at the start of the shift that the previous shift PSW had left the unit, and never returned. The next shift staff confirmed not seeing the previous shift PSW at the start of their shift on the unit. PSW confirmed a resident fall on the unit.

PSW documentation reviewed with staff confirmed hourly safety checks on resident were not completed.

Resident was neglected when the PSW left the unit unattended, during their shift, and did not report their absence to any staff members prior to leaving the unit. The resident was subsequently found on the floor, it was undetermined length of time that they had been on the ground as there was no staff on the unit.

Sources:

Record review of resident Plan of Care, Kardex, document survey report, observations of resident, interviews with staff.

[000750]

This order must be complied with by April 2, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

- Inspection workspace #2022-1355-0002. FLTCA, 2021. s. 24 (1) Issued December 20, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Plan of Care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:

1. Educate staff members involved in the Critical Incidents on what expectations for staff providing 1:1 support encompasses, and what every hour safety check responsibilities are when a resident is receiving 1:1 and/or every hour safety checks along with who completes the tasks required, where this information gets documented, who is responsible to document the information.
2. The Director of Care or designate manager will create an audit and keep a record of all residents who are receiving 1:1 and/or every hour safety checks on the units.
3. The Director of Care or a designated manager will conduct daily audits on the residents receiving 1:1 support and/or every hour safety checks on the units for a two-week period, on days, afternoons, and nights to verify that the identified residents have their 1:1 and or every hour safety check documented as per their plan of care. This will be followed with checks, completed by the Director of Care or a designated manager, to complete audits three days per

week, on days, afternoons, and night shift for a further two weeks, then weekly on each shift for one month on each unit.

4. The Director of Care or a designated manager who identified residents with 1:1 and/or every hour safety checks will keep a record of all conducted audits and any deficiencies found, along with any corrective actions taken.

5. Documented records will be kept demonstrating the retraining, education provided to staff members listed in (#1), audits completed, and corrective actions taken, when they were completed and by whom. The record is to be made immediately available to the Inspector upon request.

A) Rationale and Summary

The licensee failed to ensure that resident had 1:1 monitoring as specified in their plan of care.

Resident had a fall with injury and required medical intervention. Review of the Fall Risk Assessment that was completed for resident upon their return to the home, it stated that management initiated 1:1 observation for resident.

Review of resident's care plan indicated that, 1:1 monitoring was initiated for day, evening, and night shift due to resident recovering from previous fall.

The Long-Term Care Home (LTCH) initiated an investigation regarding another fall resident had and the results of the homes investigation determined that the 1:1 staff member assigned to monitor the resident was not with the resident at the time of their fall.

Review of resident's progress notes indicated they had a fall and that the 1:1 staff member was not with resident at time of their fall.

During an interview with staff, they indicated the expectation would be for the 1:1 staff member assigned to monitor resident would be always with the resident as directed and acknowledged that the staff member assigned as 1:1 for resident was not with the resident when they fell.

There was risk to resident when they were not monitored as per their plan of care.

Sources:

Progress Notes; Care Plan; CI Report; Fall Risk Assessments: Staff Interviews

[740915]

B) Rationale and Summary:

Resident's plan of care indicated that they were to be monitored with hourly safety checks.

Interviews with staff, confirmed PSW left the LTCH during the night shift without reporting their absence to another staff member prior to leaving the unit and LTCH. The PSW never returned to the LTCH to finish their shift, therefore leaving the unit unattended. Staff confirmed finding resident on the floor at the start of their shift and that they did not see the previous shift PSW. PSW found resident on the floor and called for help, moments later the nurse assisted as resident required medical intervention.

Interview with staff confirmed staffing assigned to the unit, were PSW independently, float PSW who covered multiple units, and a nurse. PSW documentation survey reports were reviewed with staff who confirmed hourly safety checks on resident were not completed.

There was a risk to resident as resident was not provided with every hour safety checks and interventions listed in the plan of care.

Sources:

Record review of resident Plan of Care, Kardex, document survey report (hourly safety check), observations of resident, and interviews with staff.

[000750]

C) Rationale and Summary:

During a shift the PSW was assigned to work on the unit and a nurse was assigned to cover multiple units. Resident's plan of care reported resident was to be checked every hour when laying in bed and was on every hour safety checks. Resident was found on the floor by the next shift PSW.

During the interview with staff, who confirmed during the LTCH's investigation no staff entered resident's room at which time resident was found on the floor by the PSW.

There was a risk to resident as resident was not provided with every hour safety checks and interventions listed in the plan of care.

Sources:

Record review of resident Plan of Care, Kardex, document survey report, observations of resident, interviews with staff.

[000750]

This order must be complied with by April 2, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002

Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

- Prior non-compliance with FLTCA 2021, s. 6 (7), resulting in CO #001 in inspection #2022-1355-0001, issued August 11, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.