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

Original Public Report

Report Issue Date: March 19, 2024
Inspection Number: 2024-1355-0001
Inspection Type: Complaint 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

Lead Inspector	**Inspector Digital Signature**
Patrishya Allis (000762)	

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29-31, and February 1-2, 6-7, 12, 15, 20, 2024.

The following intake(s) were inspected:

- Intake: #00103823 - regarding skin laceration
- Intake: #00104219 - regarding verbal abuse, inappropriate feeding strategies, medication mismanagement, resident's rights and choices

The following intake was completed in this inspection:

- Intake: #00108600 - regarding verbal abuse

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

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and Response System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home's resident-staff communication and response system was easily accessed and used by a resident at all times.

Rationale and Summary

The resident's care plan indicated the need for a monitoring device to be in close proximity to the resident and to attend immediately due to their risk for falls.

Observations conducted by inspector showed the monitoring device was not near the resident as it was located on their bed and resident was seated in the center the bedroom. This was acknowledged by a Personal Support Worker (PSW), who further reported resident tended to reach for desired items and was at risk for falls.

Failing to position the monitoring device in close proximity to the resident posed a risk of fall to occur as it may have contributed to resident reach for the monitoring device.

Sources: Resident room observation, resident's care plan, interview with staff.

[000762]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee has failed to ensure that a resident was protected from verbal abuse by staff.

Rationale and Summary

The Ontario Regulation 246/22 made under the Fixing Long Term Care Act, 2021 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

On a date in 2023, a Personal Support Worker (PSW) made degrading and belittling remarks to a resident. The comments were captured in the audio/video surveillance of the resident's room. The Director of Care acknowledged the remarks made were considered verbal abuse.

The home failed to ensure that the resident was protected from verbal abuse by a PSW staff.

Sources: Review of a Critical Incident, audio/video surveillance of the resident's bedroom, interview with the Director of Care, The Ontario Regulation 246/22 made under the Fixing Long Term Care Act, 2021.

[000762]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure that interventions to mitigate and manage the risk of choking were implemented.

Rationale and Summary

A resident returned to the long term care home from hospital on a date in 2023 with a diet change to regular diet, pureed texture, regular fluids. A nutrition assessment was completed upon return from hospital, which indicated the resident's swallowing was impaired and the nutritional goal was to minimize risk of aspiration; however, no mention of safe feeding strategies to mitigate or manage the risk of aspiration was indicated in the assessment or the care plan.

The Registered Dietitian and Director of Care acknowledged that safe feeding strategies, including positioning, should have been documented and made visible to front line staff in the care plan.

A Registered Nurse (RN) reported their usual practice would be to review the resident's care plan to find information about positioning and safe feeding practices, and would act accordingly.

On two occasions in 2023, a RN fed the resident medication while they were laying

down in bed. This was captured in the audio/video surveillance of the resident's room.

The home's policy, titled "Nutritional Care and Hydration: Safe Eating Assistance", last revised on October 1, 2023, highlighted strategies to be considered when assisting residents with eating, which included, during feeding "ensure the resident is sitting in an upright position, as close to a 90 degree angle as possible".

The resident was at risk for aspiration due to their medical diagnosis, missing documentation of safe feeding strategies in the care plan, and failure to position as close to a 90-degree angle as possible while administering medication.

Sources: Resident's clinical records, Nutritional Care and Hydration: Safe Eating Assistance Policy, interviews with staff, audio/video surveillance of the resident's bedroom

[000762]

WRITTEN NOTIFICATION: Requirements related to restraining by a physical device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.

Requirements relating to restraining by a physical device

s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:

4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)

The licensee failed to release a resident from the PASD and implement interventions as required.

Rationale and Summary

A resident required specific interventions as identified in their care plan and confirmed by the Director of Care (DOC), which aligned with the home's policy.

On a date in 2023, a Registered Nurse (RN) went into a resident's room briefly only to adjust the clip alarm. During this time, the resident had a PASD in place, and sustained a wound because of poorly maintained equipment and failure to implement the interventions identified in their care plan.

Investigation notes, and interviews with the DOC and Personal Support Worker (PSW) confirmed the interventions were not implemented on a date in 2023.

Failure to implement the interventions contributed to a delay in assessment and treatment, and increased the risk of injury.

Sources: Resident care plan, assessments, critical incident report, investigation report, the home's policy, interviews with staff.

[000762]

WRITTEN NOTIFICATION: Requirements relating to the use of a PASD

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 120 (1)

Requirements relating to the use of a PASD

s. 120 (1) Every licensee of a long-term care home shall ensure that a PASD used under section 36 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained.

The licensee has failed to ensure that a Personal Assistance Service Device (PASD) used under section 36 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance.

Rationale and Summary

A PASD was implemented for a resident on a date in 2018.

The substitute decision maker (SDM) signed a consent form on a date in 2023 to implement a device, which included they understood the risks. The Director of Care (DOC) confirmed this was the most recent consent form signed by the SDM. No further evidence available to suggest the SDM was contacted about the use of the device past the specified date.

A Registered Practical Nurse (RPN) reported the resident's condition was declining and a Personal Support Worker (PSW) reported the use of the device was not safe.

On a date in 2023, a resident sustained a wound due to the device.

After the incident occurred, the physiotherapist discontinued the device due to the resident's functional decline. The SDM was contacted by the DOC, and they consented to remove the device at that time.

Review of an assessment form to measure the appropriateness of the device was not thoroughly completed prior to the incident, and was therefore considered an incomplete assessment as it did not provide an accurate representation of the resident's condition, this was confirmed by the DOC. The assessment form was completed after the incident, and showed the device was not suitable for the resident.

The licensee failed to provide a thorough and complete assessment to capture the resident's declining condition and the safety risk associated with the use of the device.

Failure to communicate risks associated with the use of the device as the resident's condition was declining prevented the SDM from making an informed decision regarding its use, this placed the resident at risk of injury as the device no longer provided assistance.

Sources: consent form, progress notes, interviews with staff, assessments.

[000762]

WRITTEN NOTIFICATION: Requirements relating to the use of a PASD

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 120 (2) (a)
Requirements relating to the use of a PASD
s. 120 (2) Every licensee shall ensure that a PASD used under section 36 of the Act,
(a) is well maintained;

The licensee has failed to ensure that a personal assistance service device (PASD) was well maintained.

Rationale and Summary
A resident sustained a wound on a date in 2023. This required treatment and a referral for wound care.

Interviews with the Registered Nurse (RN) and Personal Support Worker (PSW) confirmed the wound was a result of poor maintenance of the device. The Director of Care (DOC) confirmed the device was not safe.

Review of an assessment completed by the Environmental Service Manager (ESM), indicated the resident's device was assessed for functionality and safety months prior to the incident. The ESM confirmed the condition of the device was not monitored by any member within the environmental service department from the assessed date until the date of the incident.

Failure to monitor the condition of the device posed a risk to the safety of the resident, as it led to the development of an injury requiring treatment.

Sources: Progress notes, interviews with staff, critical incident report. [000762]