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: October 24, 2024
Inspection Number: 2024-1355-0003
Inspection Type: Proactive Compliance Inspection
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26-27, and October 1- 4, and 7-10, 2024.

The following intake(s) were inspected:

- Intake: #00127506, was a Proactive Compliance Inspection (PCI) for West Oak Village.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee has failed to ensure that the name and position of the designated lead for the continuous quality improvement (CQI) initiative was contained in the 2023 CQI Initiative Report.

Rationale and Summary
A review of the home's 2023 CQI Initiative Report, dated April 2, 2024, did not contain the name and position of the designated lead for the CQI initiative. The

report did include a name, however, it was confirmed that the name on the report was not the home's designated lead.

The CQI Initiative Report was edited to reflect the correct name and position of the designated lead.

WRITTEN NOTIFICATION: Plan of Care - Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan.

Rationale and Summary
A resident's care plan specified that they were totally dependent on two staff for several activities of daily living (ADL) due to a condition.

A review of the resident's clinical records demonstrated several dates in a span of two months when care was provided by one staff member.

A staff member stated that they were aware that the resident required two staff for care; however, they sometimes provided care without having a second staff member present.

Failure to ensure that care set out in the plan of care was provided as specified, may have put the resident at risk of injury.

Sources: A resident's clinical records, staff interview.

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Rationale and Summary
A resident's plan of care specified that they required extensive assistance from two staff for two ADLs.

A review of the resident's clinical records demonstrated several dates in a span of two months when care was documented as provided by one staff member.

The Director of Care (DOC) and a Personal Support Worker (PSW) confirmed that the care set out in the resident's plan of care was not documented accurately as provided related to two ADLs.

Failure to document the provision of care set out in the plan of care could have put the resident at risk of injury.

Sources: A resident's clinical records, staff interviews.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the carpet in the home was maintained in a good state of repair.

Rationale and Summary
During the initial tour of the home and a subsequent observation in different parts of the home; multiple areas were observed where the carpet was heavily soiled and stained, and not kept in good state of repair.

The home had a policy which stated that to maintain a clean and pleasant looking environment, the carpets would be cleaned where soil was embedded in the carpet and could not be removed with vacuuming. There was also a schedule of carpet cleaning that was being followed. However, the carpet in three home areas and a resident room, were observed soiled and/or stained, and not in good repair.

The Executive Director (ED) acknowledged that the carpet was not in good state of repair in different areas of the home.

Sources: Observations; interview with the ED.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee has failed to comply with their Door Safety policy to ensure that all doors leading to secure outside areas, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

Rationale and Summary
In accordance with Ontario Regulation (O. Reg.) 246/22, s.11. (1) b, the licensee was required to ensure that a policy they put in place was complied with.

Specifically, staff did not comply with the "Door Safety" policy which stated that all doors leading to stairways and the outside of the Home must be kept closed and locked and equipped with a door access control system that was kept on at all times.

During an observation, a door leading to a fenced outdoor area in a dining room, was observed to be unlocked.

A staff member verified with the inspector that the door was unlocked, and indicated that it was unlocked when a family member asked to use the outdoor space earlier in the day. The staff verified that the outdoor area was no longer being used by a family member or resident, at the time of observation.

The ED verified that the door in the home area dining room which led to a fenced outdoor area should have been locked when the outdoor area was no longer being used.

Sources: Observation; the home's Door Safety Policy; interviews with staff.

WRITTEN NOTIFICATION: Doors in a home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas was kept closed and locked when they were not being supervised by staff.

Rationale and Summary
During an observation, a housekeeping door on the first floor; a soiled utility room, and a staff washroom on the second floor, were noted to be unlocked while

unsupervised by staff.

The home's policy stated that all doors leading to non-residential areas must be kept closed and equipped with locks to restrict unsupervised access to those areas by residents.

Different staff members verified that the doors should have been kept locked when unsupervised.

Sources: Observation; the home's Door Safety Policy; interviews with staff members.

WRITTEN NOTIFICATION: Communication and response system

NC #007 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 was equipped with a resident-staff communication and response system that, could be easily accessed and used by residents at all times.

Rationale and Summary
A. During an observation, a resident was observed sitting in their wheelchair in their room while their call bell was not within their reach.

A staff member verified that the resident's call bell was not accessible to the resident and provided the resident with their call bell.

B. During an observation, a resident was observed sitting in their wheelchair in their room while their call bell was observed to be on their bed. The resident was observed trying to obtain their call bell, but they could not reach it.

A staff member verified that the resident's call bell was not accessible to the resident and provided the resident with their call bell.

There was a risk that the residents would not have been able to call for assistance that they needed, as their call bells were not accessible to them while they were in their rooms.

Sources: Observation of resident care; interviews with staff members.

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure that a resident's plan of care related to pain was based on an interdisciplinary assessment.

Rationale and Summary
A resident started to experience severe pain on an identified date. A Point Click Care (PCC) Pain Assessment V2 was completed on the same date, however, there was no evidence of completion of an interdisciplinary assessment in the resident's care plan or progress notes.

The Pain Management Program Lead verified that pain assessments for the resident was not based on an interdisciplinary assessment.

Failure to ensure that the resident's plan of care related to pain was based on an interdisciplinary assessment, put them at risk of unresolved pain.

Sources: A resident's clinical record, interview with Pain Management Program Lead.

WRITTEN NOTIFICATION: Required Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program to identify pain in residents, and manage pain was implemented.

Rationale and Summary
On an identified date, a resident had a significant change in status and started to receive palliative care. Pain screening was not completed, and pain monitoring was not initiated.

The LTC-Pain Intervention and Monitoring Procedure stated that pain monitoring was to be initiated with a change in condition and the LTC-Pain Assessment Procedure required all residents with a change in condition to be screened for pain.

A registered staff, and the Pain Management Program Lead confirmed that a significant change in status included initiating palliative care, and pain screening, should have been completed and pain monitoring should have been initiated.

Failure to implement the pain management program could have led to poor pain management for the resident.

Sources: A resident's clinical records, staff interviews, LTC-Pain Intervention and Monitoring Procedure (last reviewed March 31, 2024), LTC-Pain Assessment Procedure (last reviewed March 31, 2024).

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to follow their pain management program for a resident.

In accordance with O. Reg. 246/22, s.11. (1) (b), the licensee was required to ensure the pain management program provided for monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Specifically, staff did not comply with the Pain Assessment and Symptom Management Program Policy and the LTC-Pain Assessment Procedure, both dated March 31, 2024, which were included in the licensee's Pain Management Program.

Rationale and Summary
On two identified dates, a resident had their pain level assessed, and was administered medication to manage the pain. However, a follow-up pain assessment was not completed to determine effectiveness and the resident's response.

The home's policy, Pain Assessment and Symptom Management Program, stated that the effectiveness of pain management interventions must be evaluated. The LTC-Pain Assessment Procedure stated that the effectiveness of pain interventions was to be monitored, and resident outcomes evaluated.

The pain management program lead confirmed that the resident's response, and the effectiveness of the pain management interventions were not evaluated.

Failure to evaluate the resident's response, and the effectiveness of the pain management interventions put the resident at risk of experiencing unresolved pain.

Sources: A resident's clinical records, Pain Assessment and Symptom Management

Program (reviewed March 31, 2024), LTC-Pain Assessment Procedure (reviewed March 31, 2024), Pain Management Program Lead interview.

WRITTEN NOTIFICATION: Pain Management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
On two identified dates, the resident's pain level was assessed on the Numerical Pain Scale.

Follow-up pain assessments were completed each time using the PAINAD, a scale used for cognitively impaired residents.

The resident's care plan stated that their pain was to be assessed using an appropriate monitoring tool.

A registered staff member, and an Assistant Director of Care (ADOC) confirmed that the resident was not assessed using a clinically appropriate assessment instrument, when the resident's pain was not relieved by initial interventions, as they were not

cognitively impaired.

The resident was not assessed using a clinically appropriate assessment instrument after their pain was not relieved by initial interventions, putting them at risk of experiencing unresolved pain.

Sources: A resident's clinical records; registered staff member, and ADOC interviews.

WRITTEN NOTIFICATION: Housekeeping

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that the procedures as part of the organized program of housekeeping were implemented, related to cleaning and disinfection of resident care equipment such as tubs and shower chairs.

Rationale and Summary
During an observation, the tub and shower chair in a Home Area's Spa Room were

noted to be soiled and dirty.

The home's policies stated that all noncritical, reusable equipment that has been in direct contact with a resident would be cleaned and disinfected before use with another resident; and that equipment would be cleaned after use.

A staff member verified that after equipment was used on a resident, they would clean and disinfect the equipment. However, they verified that the tub and shower chair in the Spa Room were soiled and dirty.

The DOC identified that the tub and shower chair should have been cleaned between use, and after use.

There may have been an increased risk of transmission of disease when shared resident care equipment's cleaning and disinfection were not implemented.

Sources: Observation; the home's Cleaning and Disinfecting policy, and Bathtub Cleaning and Disinfecting policy; interviews with a staff member, and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, Additional Requirement under Personal Protective Equipment (PPE) 6.1, stated that the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level or risk.

During an observation, a resident was noted to be on droplet and contact precautions. There were no gowns available at point of care where all the other PPE were located.

A staff member verified that staff needed to wear full PPE, including gowns when going into the resident's room. They verified that there were no gowns available in the PPE caddy.

The DOC acknowledged that gowns should be available and accessible at point of care.

There may have been a risk of increased transmission of communicable disease when all the required PPE was not available at point of care.

Sources: Observation; interview with a staff member, and the DOC.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that their drug and disposal policy was complied with.

Rationale and Summary
In accordance with O. Reg. 246/22, s.11. (1) b, the licensee was required to ensure that a policy they put in place was complied with.

Specifically, staff did not comply with the home's "LTC Narcotics and Controlled Drugs Management" policy, which stated that there was a separate storage area for discontinued narcotics and controlled drugs; and that narcotics and controlled drugs awaiting destruction must always be double-locked.

The inspector conducted an observation of the separate storage area for discontinued narcotics and controlled drugs, with a registered staff member. The storage area was an affixed box located in a Home Area, inside a locked medication room. Within the medication room, it was inside a cupboard that had a padlock. The padlock was not locked. The box had two locks which were locked. There was a slot and a round opening to insert the discontinued narcotics into the locked box. However, a narcotic was observed resting on the slot of the box rather than inside the box.

The registered staff member, and the DOC verified that the narcotic sitting on the slot of the box was not double-locked, as it was only locked behind the medication room door.

There may have been a risk to the security of controlled substances when the home did not ensure that all narcotics were double-locked.

Sources: Observation; the home's LTC Narcotics and Controlled Drugs Management policy, last revised March 31, 2024; interviews with a registered staff member, and the DOC.