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

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 30, 2023

Inspection Number: 2023-1356-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

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

Long Term Care Home and City: Winbourne Park, Ajax

Lead Inspector	**Inspector Digital Signature**
Miko Hawken (724)	Miko Hawken Digitally signed by Miko Hawken Date: 2023.06.02 14:56:50 -04'00'

Additional Inspector(s)
Amandeep Bhela (746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8 -11, 15, 17, 18, 2023
The inspection occurred offsite on the following date(s): May 12, 15 - 19, 2023

The following intakes were inspected:

- Three intakes related to staff to resident abuse/neglect.
- An intake related to Follow-up to Compliance Order (CO) #001 from inspection #2022-1356-0002 regarding FLTCA, 2021 s. 19 (2) (c).
- An intake related to responsive behaviours.
- A complaint related to concerns with neglect.
- An Intake related to a fall with transfer to hospital.

The following intakes were completed in this inspection:

- An intake related to responsive behaviours.
- An intake related to a fall with transfer to hospital.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2022-1356-0002 related to FLTCA, 2021, s. 19 (2) (c) inspected by Amandeep Bhela (746)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the home's written policy on zero tolerance for abuse was complied with.

Rationale and Summary

A critical incident report (CIR) report was submitted to the director for an allegation of abuse of resident by a personal support worker (PSW) . A review of the home's investigation notes indicated that a family member who had visited the home, spoke with a Registered Nurse (RN) and lodged an allegation of abuse against the PSW. The RN did not remove the PSW immediately and did not report the allegation of abuse to the Executive Director of designate.

Interview with the PSW indicated that they were informed by the RN during the shift, that the family member reported that they had abused their family member. The PSW indicated that after they were informed of this, they continued to work the remainder of their shift.

Review of the home's policy titled, "Resident Non-Abuse", last updated in March 2023, indicated that if there is any allegation towards a staff member, they will be suspended on administrative leave with pay immediately, until an investigation is complete. The policy further indicates that, anyone who becomes aware of, or suspects abuse or neglect of a resident, must immediately report that information to the Executive Director or designate.

Executive Director (ED) confirmed the RN did not follow the home's abuse policy as they did not immediately put the PSW on administrative leave and did not report the allegation of abuse to the Executive Director of designate.

Failure to follow the policy, resulted in the possibility that this resident continued to be abused by the PSW.

Sources: Home's investigation notes, Home's policy titled, "Resident Non-Abuse", last updated on March 2023, and Interviews with PSW, RN, and ED.
[746]

WRITTEN NOTIFICATION: 24-HOUR ADMISSION CARE PLAN

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (1)

The Licensee has failed to ensure that hat a 24-hour admission care plan was developed for a resident.

Rationale and Summary

A critical incident report (CIR) was submitted to the director related to a fall by which a resident was taken to hospital.

A review of resident's 24-hour admission care plan showed that the care plan was not fully completed within the 24 hour of the admission of the resident. The long term care (LTC) home uses a Move-In Assessment/24-Hour Care Plan within Point Click Care (PCC) and several sections of this assessment, including the resident safety assessment, was not completed and signed off by a registered staff member.

The LTC homes policy under the LTC - Move-in Assessment Process, indicated that an interdisciplinary team will create an initial Care Plan and initiate the plan of care based on the assessment completed

within 24 hours of the residents move in, specifically the Move-in Assessment/24 hour Care Plan user defined assessment (UDA) in PCC to be completed the day of the move to initiate the completion of the 24 hour Care Plan.

The homes acting director of care (DOC) confirmed that the Move-In Assessment/24 hour Admission Care Plan was not completed for the resident.

As the 24 hour care plan was not completed there was an increased risk to the resident's safety and care, as the resident was not assessed fully, and interventions were not identified to mitigate risks to the resident.

Sources: Critical Incident Report, Revera policy - CARE1-010.0 - LTC - Move-in Assessment Process – Last reviewed April, 2023, resident's electronic health records and interview with acting DOC.
(724)

WRITTEN NOTIFICATION: SK=IN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A CIR was submitted regarding a resident to resident altercation which resulted in a resident sustaining an injury.

Review of the resident's clinical records and interview with an RPN confirmed that a skin assessment was not completed.

The RPN and Acting Director of Care (DOC) confirmed that a skin assessment should have been completed.

Failure to complete a skin assessment might have impacted staff from monitoring and managing the resident's skin condition.

Sources: resident's electronic health records, interview with RPN and Acting DOC.
[746]