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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 30, 2023

Inspection Number: 2023-1464-0007

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: Arbour Heights, Kingston

Lead Inspector	**Inspector Digital Signature**
Anna Earle (740789)	Anna M Earle Digitally signed by Anna M Earle Date: 2023.11.15 10:38:11 -05'00'

Additional Inspector(s)
Erica McFadyen (740804)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26 - 29 and October 3 - 5, 2023

The following intake(s) were inspected:

- Intake: #00096688 - Complaint regarding high temperatures in residents' room and staff not providing care as specified in a resident's plan of care.
- Intake: #00097254 - CI #2982-000032-23- Resident fall with injury.
- Intake: #00097696 - Complaint regarding alleged pests in the home, staffing issues and a resident fall.

The following intakes were completed in this inspection: Intake #00088805, CI#2982-000020-23; Intake #00089127, CI#2982-000021-23; Intake #00092553, CI#2982-000023-23; Intake #00093124, CI#2982-000025-23; Intake #00094352, CI#2982-000027-23; Intake #00094463, CI#2982-000028-23 and Intake #00094450, CI#2982-000029-23 were related to falls with injury.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff collaborate with each other in the assessment of a resident, and that their assessments were integrated and are consistent with and complement each other.

Rationale and Summary
During review of resident's progress notes, it was noted that on a day in July 2023, a Registered Practical Nurse (RPN) documented that a resident's wound was noted to have deteriorated.

In an interview with the RPN, it was stated that their assessment of the wound on a day in July, 2023 was consistent with their documentation. RPN stated that they did not refer these findings to the doctor (MD) or nurse practitioner (NP) for further assessment. In interviews with Director of Care and Assistant Director of Care/ Wound Care Champion, it was stated that the concerns noted by the RPN in the residents health record should have been referred to the MD or NP for further assessment.

The impact of RPN not collaborating with the MD and/or NP in the management of a resident's wound is that the wound may not have been assessed and treated by the MD and/ or NP in a timely fashion. This may have left the resident at risk for wound complications.

Sources: Resident clinical health records, MD referral book, interviews with RPN, DOC, and ADOC/ Wound Care Champion.

[740804]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that resident's compression stockings and shirt savers were applied as set out in the resident's plan of care.

Rationale and Summary
A review of a resident's plan of care indicated that the resident was to have a double layer of compression stockings applied in the morning. Inspector reviewed resident's health care records, interviewed Personal Support Worker (PSW) and Director of Care (DOC), and it was acknowledged that resident's compression stockings were applied as four layers.
A review of resident's plan of care also indicated that a shirt saver was to be worn during meals. During resident's record review and interviews with staff, it was confirmed that the shirt saver was worn beyond mealtimes for this resident.

Failure to follow a resident's plan of care places a resident at risk for not being provided the care they require.

Sources: Resident's health records, email chains between licensee and complainant with pictures included, and interviews with staff and Director of Care.

[740789]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee did not comply with their "Post-Fall Management Policy" while providing care to a resident.

In accordance with O. Reg 246/22 s. 11(1)(b) the licensee is required to ensure their written policy related to Falls Prevention is complied with. Specifically, the policy states that "If a fall is unwitnessed or the resident was witnessed hitting his/ her head during the fall, the Head Injury Routine (HIR) is initiated, and neuro vitals are monitored for 72 hours".

Rationale and Summary
Review of the clinical documentation for a resident indicated that the resident sustained an unwitnessed fall on a day in September 2023. A progress note written by a Registered Practical Nurse (RPN) stated that a Head Injury Routine (HIR) was not initiated because they assumed the family of the resident would not want them awoken overnight.

In an interview with Director of Care (DOC), it was stated that the family of this resident did not request that the Head Injury Routine (HIR) not be completed overnight following the fall of this resident. DOC stated that the RPN did not comply with the licensee's policy to initiate a HIR for an unwitnessed fall.

The risk of not completing a HIR is that neurological symptoms related to an unwitnessed fall may not be noticed.

Sources: Clinical documentation for resident, and interview with DOC.

[740804]

WRITTEN NOTIFICATION: Resident Records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (a)

The licensee has failed to ensure that the resident's written record is kept up to date at all times.

Rationale and Summary
During a review of the clinical documentation for a wound of a resident, it was noted that a skin and wound assessment was completed for the resident on a day in July 2023. No additional skin and wound assessments were noted for the month of July 2023.

During a review of the Treatment Administration Record (TAR) for a resident, it was noted that the skin and wound assessment was signed off as completed on five occasions in July 2023. None of the dates that were signed off on the TAR had a corresponding skin and wound assessment completed.

In interviews with DOC and ADOC/ Wound Care Champion, it was stated that the documentation included on the TAR for this resident was incorrect.

The risk of incorrect documentation on the TAR is that it may result in a clinical record that does not

accurately reflect the care that was provided.

Sources: Clinical record for resident, interviews with DOC and ADOC/ Wound Care Champion.

[740804]

COMPLIANCE ORDER CO #001 Duty of Licensee to Comply With Plan

NC #005 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) The Licensee shall ensure that the wound care plan of care for residents with areas of altered skin integrity is provided as per the plan.

2) Complete a weekly audit of all residents with areas of altered skin integrity who require a wound care plan of care to ensure that wound care is being provided as specified in the plan of care. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.

3) Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings, and any corrective actions taken.

Grounds
The licensee has failed to ensure that the wound care plan of care for a resident was provided as per their plan.

Rationale and Summary
On a day in August 2023, the nursing staff of the long-term care home were notified by an external nurse that a resident was experiencing a wound complication. The following day, the Nurse Practitioner wrote a wound care order for the resident requiring a treatment and dressing to be provided to the wound once daily and as needed. Review of the Treatment Administration Record for the month of August 2023 shows that this care was not provided on eight occasions during the month of August 2023. In an interview with ADOC/ Wound Care Champion and DOC, it was confirmed that the care was not provided, and the plan of care was not followed on eight occasions in the month of August 2023.

The risk of not following the plan of care for a resident as it related to wound care is that it increased the chance of wound complications.

Sources: Interviews with DOC and ADOC/ Wound Care Champion, and record review for the resident.

[740804]

The licensee has failed to ensure that the wound care plan of care for a resident was provided as per the plan.

Rationale and Summary
On a day in August 2023, it was documented in the progress notes of a resident that they were experiencing wound complications to their chronic wound. Documentation from NP on a day in August 2023, stated that the wound dressing was not completed as ordered leading to further wound complications.

In an interview with NP, it was stated that they came to the conclusion that wound care had not been completed as ordered because that is what was communicated to them by the nursing staff when the wound complications were discovered.

During a review of the Treatment Administration Record for the wound of this resident, the prescribed wound care was noted to be left blank on a day in August 2023.

In an interview with DOC and ADOC/ Wound Care Champion, it was stated that the wound care specified in the plan of care was not provided to this resident on that day in August 2023.

The risk of missing a dressing change is that wound complications may occur.

Sources: Interviews with DOC, ADOC/ Wound Care Champion, and clinical record for the resident.

[740804]

This order must be complied with by December 8, 2023.

COMPLIANCE ORDER CO #002 Skin and wound care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Licensee shall ensure that residents areas of altered skin integrity are reassessed weekly by a member of the registered nursing staff, if clinically indicated, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

2. Complete a weekly audit of all residents where a weekly wound assessment is clinically indicated, to ensure weekly assessments are being completed using a clinically appropriate assessment instrument. The audits are to be completed for a minimum of one month, or until all staff, including agency staff, are compliant with the process.

3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

4. Provide education to all staff who are required to complete wound care assessments in the long-term care home, including management and agency staff, on the licensee's skin and wound assessment process and the use of a clinically appropriate assessment instrument specifically designed for skin and wound assessments. This education should include a section on accurate documentation of wound assessments.

5. Maintain documentation of the education, including the names of the staff, their designation, and date training was provided.

Grounds
The licensee has failed to ensure that any resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff when it was clinically indicated.

Rationale and Summary
Review of the clinical record for a resident, it noted that on a day in July 2023, that their wound was assessed and was noted to be deteriorating. A subsequent wound assessment was not noted within the clinical record until a day in August 2023, 25 days later. Early August 2023, the long-term care home was notified by an external nurse that the resident was experiencing wound complications.

As documented in the clinical record the resident did not have a weekly wound assessment completed for seven of the 17 weeks between June and October 2023.

In an interview with DOC and ADOC/ Wound Care Champion it was confirmed that weekly wound assessments were not completed for this resident.

The risk of not completing wound assessments weekly is that wound complications may occur.

Sources: Clinical record for this resident, interviews with DOC and ADOC/ Wound Care Champion.

The licensee has failed to ensure that any resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff when it was clinically indicated.

Rationale and Summary
Review of the clinical record related to the chronical wound of a resident indicated that no weekly wound assessment was completed for 10 days in September 2023. In an interview with DOC and ADOC/ Wound Care Champion, it was stated that the wound was not assessed weekly in September 2023.

The risk of not completing weekly wound care assessments for residents is that changes to the wound may not be noted and acted upon.

Sources: Review of the clinical record for this resident, interviews with DOC and ADOC/ Wound Care Champion.

[740804]

This order must be complied with by December 8, 2023.

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.