Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2022	2021_918426_0007	008760-21, 009706-21, 012046-21, 014652-21, 016717-21, 018376-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Bay Ridges
900 Sandy Beach Road Pickering ON L1W 1Z4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

FRANK GONG (694426), AMANDEEP BHELA (746), BRITNEY BARTLEY (732787)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 15, 16, 17, 20, 21, 22, 23, 24, 29, 2021

The following intakes were completed during this Inspection:
Log #016717-21 related to conducting a follow-up to amended Compliance Order #002 issued to the licensee during inspection #2021_673672_0034 (A1) on November 3, 2021, and a compliance due date of November 30, 2021, regarding the home's Infection Prevention and Control program.
Log #008760-21 related to the prevention of abuse and neglect
Log #009706-21 related to the prevention of abuse and neglect and personal support services
Log #012046-21 related to the prevention of abuse and neglect
Log #014652-21 related to the prevention of abuse and neglect
Log #018376-21 related to resident fall with transfer to hospital and significant change in health condition.

A Complaint inspection (#2021_941746_0007) was conducted concurrently to this Critical Incident System Inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Behavioural Supports Ontario (BSO) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, and residents.

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions, reviewed clinical health records, internal investigation notes, staff schedules, and discussed relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #002	2021_673672_0034	694426

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Resident #002 had a history of fall-related injuries, a specified intervention was implemented in their plan of care as a fall's management intervention to reduce risk for falls.

Observations made on specified dates indicated that specified interventions were not in place, this was confirmed by staff #101 and #104 and identified as a risk. The DOC acknowledged that the lack of specified interventions may result in risk of injury to the resident.

Failure to ensure that the care set out in the plan of care was provided to the resident as specified in the plan may result in further falls and injuries to the resident.

Sources: CIS Report, observations, resident #002's plan of care and progress notes, interview with staff #101, staff #102, staff #106 and DOC. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Resident #001's plan of care required a specified transfer device for transfers. A critical incident was submitted by the home following a specified incident.

A review of the home's investigation revealed that on specified date, PSW #110 and #112 used a specified transfer device not indicated in resident #001's plan of care for transfers.

PSW #112 confirmed that resident #001 was transferred using a specified transfer device not indicated in resident #001's plan of care. PSW #112 indicated that they understood the resident's plan of care requirements.

DOC verified that resident #001 should have been transferred by an appropriate transfer device noted in the resident's plan of care. DOC indicated that staff had been trained on the Safe Resident Handling Policy. DOC further noted that failure to utilize the appropriate transfer device listed in the resident's plan of care may lead to risk of injury to both the resident and staff.

Failure to ensure that the care set out in the plan of care was provided to the resident as specified in the plan may result in physical injuries to the resident and staff.

Sources:
Critical Incident Report, the home's investigation notes, Safe Resident Handling Policy, resident #001's plan of care, Documentation Survey Report v2, and progress notes, interviews with PSW #112, RN #111, and DOC. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was protected from physical abuse by resident #004.

For the purposes of the Act and Regulation, "Physical Abuse" is defined as:
"the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident". Ontario Regulation 79/10 s. 2 (1)

Resident #004 had documented specified responsive behaviours with specified triggers. Resident #005 had documented specified responsive behaviours.

On specified date, resident #005 was found with specified injuries. A review of the

home’s investigation indicated that resident #005 had sustained specified injuries due to resident #004.

The home's investigation indicated that resident #004 and resident #005 had specified interactions immediately prior to the incident. DOC verified that physical abuse was substantiated by the home.

Failure to ensure that the residents are protected from abuse may result in physical and emotional injuries.

Sources:
Critical Incident Report, the home’s investigation notes, resident #004 and #005’s plan of care and progress notes, interviews with RPN #115, Staff #114, and DOC. [s. 19. (1)]

2. The licensee has failed to ensure that resident #014 was protected from physical abuse by resident #013.

For the purposes of the Act and Regulation, “Physical Abuse” is defined as:
“the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident”. Ontario Regulation 79/10 s. 2 (1)

Resident #013 had documented specified responsive behaviours with specified triggers.

On specified date, resident #013 was found at a specified location. Upon redirection by staff, resident #013 exhibited specified responsive behaviours that caused specified injuries to resident #014.

DOC verified that physical abuse was substantiated by the home.

Failure to ensure that the residents are protected from abuse may result in physical and emotional injuries.

Sources:
Critical Incident Report, observations, the home’s investigation notes, resident #013 and #014’s plan of care and progress notes, interviews with RPN #115, Staff #114, and DOC. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 6th day of January, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.