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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 15, 2023	
Inspection Number: 2023-1354-0001	
Inspection Type: Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Elginwood, Richmond Hill	
Lead Inspector Nicole Lemieux (721709)	**Inspector Digital Signature** Nicole S Lemieux Digitally signed by Nicole S Lemieux Date: 2023.03.23 12:45:16 -04'00'
Additional Inspector(s) Lucia Kwok (752) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 21 to 24, and 27, 2023

The following intake(s) were inspected:

- One Critical Incident Report (CIR) related to falls prevention and management

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

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

Non-Compliance with FLTCA, 2021, s. 184 (3)

1) The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, dated December 23, 2022, the licensee was required to ensure that all staff have an antigen test at least two times per week, on separate days, if they are up to date with their COVID-19 vaccines or at least three times per week if they are not up to date with the recommended COVID-19 vaccine doses.

Rationale and Summary

The home's COVID-19 testing tracker for staff indicated that a registered staff did not complete rapid antigen testing (RAT) for COVID-19 for one week. Additionally, the Infection Prevention and Control (IPAC) lead reviewed the home's internal tracking system for RAT of staff and confirmed that the registered staff had no test results documented for the same time frame as mentioned above. The IPAC lead and the Assistant Director of Care (ADOC) confirmed that the staff should have been recording their RAT results on the tracking records. Additionally, the ADOC confirmed that by staff not recording their RAT results, the home had no way of knowing if tests were completed and the results of the RAT.

Failing to ensure that staff were tested with a RAT prior to entering the home, places the residents at increased risk of infection.

Sources: The home's PanBio testing tracker titled "Long Term Care PanBio Tracker for Staff and Visitors", home's internal tracking records, COVID-19 guidance document for Long-term Care Homes in Ontario, and interviews with the IPAC lead and the ADOC. (721709)

Non-Compliance with FLTCA, 2021, s. 184 (3)

2) The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, dated December 23, 2022, the licensee was required to ensure that all residents were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary

A resident's daily COVID-19 screening records identified that there were three days during a week period when they were not assessed daily utilizing the licensee's COVID-19 screening tool. A registered staff acknowledged screening should be completed daily and documented in the resident's COVID-19 screening assessments as per the home's current process. The IPAC lead and the ADOC confirmed that a COVID-19 screening assessment was not completed and documented daily for the resident.

The resident was at risk as they were not being assessed and monitored for symptoms daily.

Sources: Resident's clinical records, COVID-19 guidance document for Long-term Care Homes in Ontario, interviews with registered staff, IPAC lead and the ADOC. (721709)

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with O. Reg. 246/22, s. 102 (9) (a), IPAC Standard 3.1 (b)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection for a resident were monitored in accordance with any standard or protocol issued by the Director.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, section 3.1 (b) states that the licensee shall ensure that surveillance is performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

A resident received medical intervention for two weeks for a diagnosed infection. Clinical records for the resident confirmed that they were not monitored for signs and symptoms of infection for several shifts during the above-mentioned time frame. A registered staff acknowledged that monitoring for signs and symptoms of infection were to be documented in a resident's progress notes every shift. The ADOC confirmed that the resident was not monitored every shift for signs and symptoms of infection and that there should have been documentation every shift.

Failing to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored increases the risk of worsening condition for the resident.

Sources: Resident's clinical records, interviews with registered staff and the ADOC. (721709)

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

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

Non-compliance with O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that protocols related to medication management for a resident were implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Best practice guidelines provided by the College of Nurses of Ontario (CNO), 2022, specifically in the practice standard for medication, provides the necessary guidance in establishing when documentation of the medication is to occur. The above-mentioned guidelines indicate that the administration of medication should be documented during and/or after the medication has been given.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a fall with injury for a resident. Clinical records for the resident indicated that they were administered pain medication twice as needed on the day of the fall. The resident's Medication Administration Record (MAR) showed no documented administration of pain medication as needed on this date as per evidence-based practices. The Director of Care (DOC) confirmed that it was registered staff's responsibility to document immediately after the administration of a medication in the resident's MAR. The DOC confirmed that the home's process was not followed and not documented accordingly.

Failing to document when medications are administered puts the resident at increased risk as they may receive additional dosing.

Sources: Resident's clinical records, College of Nurses of Ontario (CNO) Medication Practice Standard, 2022, interview with the DOC. (721709)

WRITTEN NOTIFICATION: BED RAILS

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

Non-compliance with O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that a resident's bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

A document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards", March 2008, provides the necessary guidance for completing an evaluation of a bed system. The Health Canada guide was identified by the Director of the Ministry of Long-Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety and shared with the sector.

Rationale and Summary

A CIR was submitted to the Director related to a fall with injury for a resident. During observations, Inspector #721709 noted that the resident was using bed rails with a specialized surface. The ADOC confirmed that the resident's bed rails, and specialized surface were applied on separate days after the resident's fall. Review of the Bed System Measurement Device Test Results Worksheet indicated that only one evaluation of the resident's bed system was completed.

The Environmental Services Manager (ESM) indicated a bed system evaluation is being completed annually as per the home's current process, unless there are recommendations by the DOC. The ESM also indicated that all changes to a resident's bed system is under the direction of the DOC. The DOC, ESM and ADOC confirmed that the resident's bed system should have been re-evaluated with each modification.

The resident's safety was at an increased risk when their bed system was not evaluated upon each alteration.

Sources: Observations, resident's clinical records, Bed System Measurement Device Test Results Worksheet, Zones of Entrapment Assessment schedule, The Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, interviews with the ESM, ADOC and DOC. (721709)

WRITTEN NOTIFICATION: BED RAILS

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

Non-compliance with O. Reg. 246/22, s. 18 (1) (b)

The licensee has failed to ensure that where bed rails are used for a resident that steps are taken to prevent entrapment, taking into consideration all potential zones of entrapment.

Rationale and Summary

A CIR was submitted to the Director related to a fall with injury for a resident. During observations, Inspector #721709 noted that the resident was using bed rails with a specialized surface. The resident's bed rail assessment indicated that the resident was not a candidate for bed rails as per questions

outlined in the home's assessment. Review of the Bed System Measurement Device Test Results Worksheet indicated that only one evaluation of the resident's bed system was completed. The results of the worksheet indicated that not all zones were tested, and the ESM confirmed the same.

The Zones of Entrapment Assessment schedule indicated that the resident failed an entrapment test. The ESM noted that when a resident's bed system fails an entrapment test, it is brought to the attention of the DOC to make recommendations of solutions to mitigate risk to the resident. The ESM was unaware of actions taken once the resident failed the entrapment test. There was no record available to indicate what was in place to mitigate risk to the resident related to the failed entrapment test. The ADOC confirmed that the resident was at risk with having bed rails installed.

The resident's safety was at an increased risk when bed rails were applied to their bed not taking into consideration zones of entrapment and interventions to mitigate risk.

Sources: Observations, resident's clinical records, Bed System Measurement Device Test Results Worksheet, Zones of Entrapment Assessment schedule, interviews with ESM, ADOC and DOC. (721709)

WRITTEN NOTIFICATION: COMPLIANCE WITH MANUFACTURER'S INSTRUCTIONS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg 246/22, s. 26

The licensee has failed to ensure that staff used a resident's bed system, specifically their specialized surface, in accordance with the manufacturers' instructions.

Rationale and Summary

A CIR was submitted to the Director related to a fall with injury for a resident. During observations, Inspector #721709 noted that the resident was using bed rails with a specialized surface.

The guidance document titled "The Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", dated March 17, 2008, indicates that all beds should be marked with mattress compatibility information as a mattress of improper type, size or thickness can create potential entrapment hazards. The ESM confirmed that the manufacturer's manual was unavailable in the home. Upon retrieving the manufacturer's manual for the resident's specialized surface, it indicated that risk of entrapment may occur when the equipment is placed on bed frames that leave gaps and have not been assessed and evaluated in accordance with best practice guidelines for bed rail safety. The ESM and ADOC were unaware of requirements for labeling as per best practice safety guidelines. The ADOC confirmed the resident was at risk when staff were unaware of the manufacturer's instructions for the correct use of the bed system.

The resident's safety was at risk when using a specialized surface in conjunction with bed rails without following the manufacturer's instructions.

Sources: Observations, The Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, bed surface manufacturer's instructions, interviews with the ESM and ADOC. (721709)

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident received a skin and wound assessment upon return from hospital.

Rationale and Summary

A CIR was submitted to the Director related to a fall with injury for a resident. The resident was transferred to the hospital for evaluation of their injury. Upon their return, the resident's clinical records indicated that they sustained an injury with a significant change in status. Furthermore, clinical records for the resident indicated that a skin and wound assessment was not completed upon return from the hospital. The ADOC confirmed that a skin and wound assessment should be completed by registered staff upon return from the hospital and was not completed for the resident for three days after their return.

Failing to complete a skin and wound assessment upon return from the hospital places the resident at risk for complications related to unidentified skin issues.

Sources: Resident's clinical records, interview with the ADOC. (721709)

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg 246/22, s. 57 (1) 4

The licensee has failed to ensure that a resident's responses to and the effectiveness of pain management strategies were monitored.

Rationale and Summary

A CIR was submitted to the Director related to a fall with injury for a resident. The resident was transferred to the hospital the following day, after the fall, for re-assessment. During this time frame,

the resident was experiencing pain and was given pain medication four times as needed. Clinical records indicated that the resident was administered pain medication twice on the same shift they fell however, they continued to complain of pain and discomfort as the pain medication was ineffective. Additionally, pain medication was administered two more times, however, the effectiveness was not monitored in a timely manner, until the next intervention was administered. The resident's 72-Hour pain monitoring sheet captured no documentation related to the monitoring of the effectiveness of the pain medication.

A registered staff indicated that effectiveness of pain management strategies, specifically medications, would be documented utilizing the MAR and the 72-Hour pain monitoring tool. The DOC confirmed that the interventions were not monitored for effectiveness and the documentation was incomplete in both the progress notes and on the 72-Hour pain monitoring record.

The resident was at risk for increased pain and discomfort when the pain interventions were not monitored for effectiveness.

Sources: Resident's clinical records, 72-Hour pain monitoring record, interviews with registered staff and the DOC. (721709)