

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

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| Report Issue Date: September 12, 2023 | |
| Inspection Number: 2023-1354-0003 | |
| 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: Elginwood, Richmond Hill | |
| Lead Inspector Deborah Nazareth (741745) | Inspector Digital Signature |
| Additional Inspector(s) Suzanna McCarthy (000745) | |

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 10, 11,14-18, 21-24, 2023.

The following intake was completed in this complaint inspection:

- One intake related to abuse and neglect.

The following intakes were completed in this Critical Incident (CI) inspection:

- One intake related to resident to resident abuse.
- Four intakes related to staff to resident abuse.
- Two intakes related to neglect.
- One intake related to improper care.
- One intake related to fall prevention and management.

The following intakes were completed in this inspection: six intakes related to falls.

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

- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

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

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

Rationale & Summary

During several observations in this inspection, it was noted that there was an area of flooring in one home area that had lifted off the floor in three areas resulting in three raised ridges below a handrail. The Environmental Services Manager (ESM) indicated that they had been aware of this deficiency following the completion of a safety audit in July, 2023. The ESM reported that they attempted to repair the floor utilizing weights and a roller but were not successful. The ESM reported that a request was made to the Executive Director (ED) to order supplies from an online retailer and the flooring would be repaired once the required supplies arrived. By the end of the inspection, the home received the items required to address the uneven flooring, but the repair was incomplete.

Failing to maintain the home in a good state of repair created a safety hazard for the residents.

Sources: Observations, interviews with ESM and ED, Safety Audit dated July, 2023.
[000745]

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WRITTEN NOTIFICATION: Communication and response system

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

Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that the resident-staff communication and response system was always easily seen, accessed, and used by a resident.

Rationale and Summary

The Long-Term Care Home (LTCH) submitted a Critical Incident Report (CIR) related to the fall and hospitalization of a resident. The resident's plan of care indicated they had a risk for falls related to their health condition. The resident's care plan documented their communication device was to be placed within their reach. During an observation the resident was observed awake, lying in their bed. Their communication device was not within reach of the resident. The communication device was found under the bed where the resident was unable to see and access it to use.

A Personal Support Worker (PSW) came to the resident's room and confirmed the communication device should not have been left in this position and repositioned it within reach of the resident. Multiple staff including the Clinical Lead stated the expectation was for the communication device to be within residents' reach when in bed.

The resident was at risk for falls and having their needs unmet when their communication device was not placed within their reach.

Sources: Observations, resident's clinical record, Universal Fall Prevention Strategies, CARE5-P10-E2, last revised October 27, 2016, interviews with PSW, Clinical Lead and others.
[741745]

WRITTEN NOTIFICATION: Bathing

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

Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that a resident was bathed at a minimum twice a week by the method of their choice.

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Rationale and Summary

A CIR was submitted to the Director with regards to the scheduled bathing of a resident. On a specified day, a resident was informed that due to staffing issues, their shower would be rescheduled for the next day. Documentation indicated that the bath missed on the specified day, was not rescheduled which resulted in the resident only being bathed once in the seven-day period.

It was confirmed through interviews with staff that residents are to be bathed at minimum twice a week and should a bath be missed, the expectation is that it is completed the next day. The Director of Care (DOC) also stated the expectation is that residents are bathed twice a week. If scheduled bathing is not provided, it is to be completed within the next two days.

By not ensuring the resident's shower was rescheduled, the resident was at risk for poor hygiene outcomes and discomfort.

Sources: Resident's clinical record, interviews with PSW, RPN, and DOC.
[000745]

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1. The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed related to cleaning and Routine Practices and Additional Precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 5.3 (h), the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including cleaning and disinfection.

Rationale and Summary

During the inspection, this home was in respiratory outbreak. During an observation a housekeeper and PSW were observed moving a transferring device from the room of a resident

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on additional precautions to a storage room. This resident was on additional precautions for a potential infection at the time. The staff were not observed cleaning the equipment prior to storing it. The IPAC Manager confirmed the transferring device should have been disinfected by staff prior to being placed back in the storage area.

When the staff did not disinfect the transferring device there was a risk of harm to residents and possible transmission of infectious agents.

Sources: Observations, interview with IPAC Manager.
[000745]

2. The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed related to hand hygiene.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 9.1 (b), the licensee shall ensure hand hygiene, including, but not limited to, at the four moments of hand hygiene is completed by staff.

Rationale and Summary

During this inspection, the home was in respiratory outbreak. During an observation, a housekeeping staff was observed entering the room of a resident who was on precautions for potential infection. The housekeeping staff interacted with the resident's environment and exited the room multiple times without performing hand hygiene.

During interviews with the housekeeping staff and the IPAC manager, both acknowledged that hand hygiene should have been completed.

Failure to complete hand hygiene during, but not limited to, the four moments of hand hygiene may result in further spread of infectious diseases.

Sources: Observations, interviews with Housekeeping Staff and IPAC Manager.
[000745]