Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 23, 2024	
Original Report Issue Date: April 30, 2024	
Inspection Number: 2024-1330-0002 (A1)	
Inspection Type: 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: Longfields Manor, Nepean	
Amended By Shevon Thompson (000731)	Inspector who Amended Digital Signature Shevon Thompson (000731)

AMENDED INSPECTION SUMMARY

This report has been amended to:

This report was amended to remove Written Notification #001 based on additional information gathered. Written Notification #002 and Compliance Order #001 are included in this report however they were not amended; therefore, the served date remains April 30, 2024.

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Lead Inspector Shevon Thompson (000731)	Additional Inspector(s)
Amended By Shevon Thompson (000731)	Inspector who Amended Digital Signature

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This report has been amended to:

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 26, 27, and 28, 2024 and April 2, 3, and 4, 2024

The following intake(s) were inspected:

- Intake: #00105873 - CIR #2845-000001-24 - COVID-19 Outbreak - Declared on January 5, 2024 and finalized on February 22, 2024.
- Intake: #00110478 - CIR #2845-000006-24 - Fall of a resident resulting in an injury for which the resident was transferred to the hospital.
- Intake: #00110570 - CIR #2845-000007-24 - Written complaint to the home in regards to the care of a resident after a fall.
- Intake: #00111543 - CIR #2845-000010-24 - Complaint to home in regards to a medication error.

The following Inspection Protocols were used during this inspection:

Medication Management
Infection Prevention and Control
Falls Prevention and Management

AMENDED INSPECTION RESULTS

(A1)
The following non-compliance(s) has been amended: NC #001

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program was complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), where

the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any, plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.
Specifically, the licensee has failed to 1)complete a head injury routine (HIR) for a resident's fall and failed to ensure that the resident was not moved from where they had fallen.

#1
Rationale and Summary:
In a review of a progress note it was noted that a resident had an unwitnessed fall and the neurological flowsheets had been started. The neurological flow sheet was reviewed by the inspector and it was noted that the resident's fall occurred on a specific date and time. The Instructions required a total of 72 hours monitoring. The last entry on the Neurological flowsheet was noted to be 14 hours prior to the required 72 hours completion time specified.

During a review of the homes Procedure for fall prevention and injury reduction the inspector noted the following information:
A procedure titled, Post fall management, CARES-010.05 with review date of March 31, 2023 detailed that; A post- fall assessment is completed by the nurse immediately following the fall, including vitals signs every shift for a minimum of 72 hours. If a fall is un-witnessed or the resident was witnessed hitting his/her head during the fall, the Head Injury Routine is initiated, and neurological vitals are monitored for 72 hours.
A procedure titled, Head Injury Routine CARES - 010.06 with review date of March 31, 2023 detailed in the Procedure - the nurse will - complete the Neurological flowsheet.

In an interview with a staff member, they confirmed that if a resident's fall was unwitnessed the head injury routine was to be done for 72 hours.
The Executive Director (ED) confirmed that the duration of time for the Head Injury Routine, Neurological flowsheet, to be completed was 72 hours.

Failure to ensure that the fall prevention and management program is complied with places the resident at an increased risk for any changes in their condition to go unnoticed and untreated.

Sources: resident's electronic health record, home's Post fall management, CARES-010.05 with review date of March 31, 2023, and home's Head Injury Routine CARES - 010.06 with review date of March 31, 2023, interview with staff and ED. [000731]

#2
Rationale and Summary:
In a review of the home's investigation file the inspector noted an Interview, of a staff member by the ED, in which the staff member confirmed that after the resident had fallen they had gotten the resident up.
In a review of the homes procedure titled, Head Injury Routine CARES - 010.06 with review dates March 31, 2023, the inspector noted the following; Procedure - the nurse will - complete the Neurological flowsheet: Do not move the resident if a head injury is suspected.

In an interview with a staff member they confirmed that if a resident had fallen and If they had a head injury the staff was not to get them up.
The ED confirmed that the home's policy/procedure that states "Do not move the resident if a head injury is suspected" was expected to be followed by staff especially if there was significant head injury and affirmed that in the case of that

resident it was not the expectation that the resident would have been moved.

Failure to ensure that the fall prevention and management program is complied with places the resident at an increased risk for further injury.

Sources: home's Head Injury Routine CARES - 010.06 with review date of March 31, 2023, home's investigation file, interview with staff and ED. [000731]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
#1
The Licensee shall:

A) Provide education to two staff members on the proper procedure for doffing Personal Protective Equipment for residents on isolation precautions.

B) Conduct audits on the proper doffing of PPE by the specified staff. Audits are to be completed for each staff member, for a minimum period of four weeks, three times per week on a minimum of two residents that are on isolation precautions.

C) Take corrective actions, if any deviation from the procedure for the proper doffing of PPE are identified during the audits required in section (B), to ensure compliance with the applicable legislation;

D) Keep written records of everything required under steps (a), (b), (c) and (d) of this compliance order, and must include; a copy of the training provided, those who attended with dates/times, as well as the name of the person who provided the training, the names of the residents that were on precautions during the audits, the dates and times of the audits, who completed the audits and any corrective action that was taken if deviation was identified during the audits. The written records that are to be kept for the requirements under steps (a), (b), (c) and (d) of this compliance order, must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

#2
The Licensee shall:

A) Conduct audits on Hand Hygiene assistance to ensure all residents are offered assistance with Hand Hygiene in the dining room. Audits are to be completed for each unit for all three meals breakfast lunch and supper, for a minimum period of four weeks, three times per week on a minimum of two units each audit. Audits are to include all residents that presented to the dining room for the meal.

B) Take corrective actions, if any deviations are identified during the audits required in section A), to ensure compliance with the applicable legislation.

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C) Keep written records of everything required under steps (a), (b), and (c) of this compliance order, and must include; a copy of the audits completed, as well as the name of the person who completed the audits, the dates and times of the audits, the unit and meal that was audited and any corrective action that was taken if deviation was identified during the audits. The written records that are to be kept for the requirements under steps (a), (b), and (c) of this compliance order, must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure compliance with any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee has failed to ensure compliance with section 9.1 (d) of the IPAC Standard for Long-Term Care Homes that Routine Practices and Additional Precautions were followed in the IPAC program that at minimum Routine Practices included proper use of PPE, including appropriate selection, application, removal, and disposal, when two staff members exited the resident's room.

Rationale and Summary:
On a specific date the inspector noted a room had contact precaution and donning signage above a PPE cart located outside the room. A disposal bin, doffing signage and a wall mounted ABHR was located inside the entrance to the room. Two staff members were noted inside the room wearing masks, gloves and gown. One of the staff members doffed their gown, kept on their gloves and mask and exited the room then proceeded down the hall to retrieve a clean bed sheet prior to reentering the room. Later, both staff members were observed to exit the room doffing their gowns, then gloves then performing Hand Hygiene with ABHR.

In an interview with one of the two staff members, they confirmed that, on exiting the room, they had removed their gown but not their gloves and had not performed any Hand Hygiene, when they had gone to retrieve a clean sheet and reentered the room. They verified that the expectation when wearing PPE and leaving the room of a resident on contact precautions was to remove their gloves, perform Hand Hygiene prior to doffing their gown and again perform Hand Hygiene after removing their gown.

The other staff member confirmed that on exiting the room they had removed their gown but not their gloves or mask and had not performed any hand hygiene. They were unable to verify the correct process for doffing their gloves and gown and performing hand hygiene.

In an interview with the IPAC Lead they verified that when leaving the room of a resident that was on contact precautions the staff members were expected to first remove their gloves, perform hand hygiene than remove their gown and again perform hand hygiene.

Failure in the proper use of PPE, including appropriate selection and application placed the staff member at an increased risk of contracting infectious pathogens and transmitting these infectious pathogens to other residents.

Sources: observation on a unit, interview with staff and the IPAC Lead [000731].

The licensee has failed to ensure compliance with any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee has failed to ensure compliance with section 10.4 (h) of the IPAC Standard

for Long-Term Care Homes that residents are provided assistance to perform hand hygiene before meals and snacks.
Rationale and Summary:
On a specific date in March the inspector was observing a unit dining room and at 1225 hours noted a resident self propelling in a wheelchair to enter the dining room. No Hand Hygiene(HH) assistance was offered to the resident by staff.

In another unit dining room, the inspector noted a residents entered the dining room using their walker and was not provided assistance with Hand Hygiene. Two other residents entered the dining room, using their walkers and an independent resident walked into the dining room carrying a newspaper, but none of these residents were provided any assistance for Hand Hygiene.

In an interview with a resident they confirmed that they had not received any offer of assistance with hand hygiene, from staff, at lunch that day.

In a second resident interview they confirmed that they had not received assistance with Hand Hygiene from staff prior to eating their lunch meal.

The IPAC Lead affirmed that the staff were expected to offer hand hygiene assistance to all residents prior to snacks and meals.

Not providing assistance to residents, to perform hand hygiene prior to meals, places the residents at an increase risk of contracting and transmitting infectious pathogens.

Sources: observation of lunch meals in two unit dining room, interview with resident and the IPAC Lead. [000731]

This order must be complied with by July 18, 2024.

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REVIEW/APPEAL INFORMATION

TAKE NOTICEThe 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.