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

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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
Dec 9, 2020	2020_543561_0013	003077-20, 003645-20	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

Northridge
496 Postridge Drive Oakville ON L6H 7A2

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

DARIA TRZOS (561)

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): November 12, 13, 17, 18, 20, 23, 24, 25, 26, 2020.

This inspection was conducted related to the following critical incident (CI) intakes:
log #003645-20, CI 2862-000006-20 - related to a fall with injury,
log #003077-20, CI 2862-000003-20 - related to a fall with injury.

A Complaint inspection number 2020_543561_0014 was conducted concurrently with this inspection.
Inspector #585 was present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Physiotherapist (PT), Resident Assessment Instrument (RAI) Coordinator, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector observed provision of care, reviewed clinical records, investigation notes, policies and procedures, evaluations of programs and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident after a fall.

On an identified date in 2020, a resident had an unwitnessed fall and an unsafe transfer was performed by staff. The home's policy titled "Safe Resident Handling", effective August 31, 2016, stated that the procedure for staff was to use a mechanical lifting device to lift residents from the floor who have fallen, have been assessed by a registered staff member and do not have the physical abilities to assist themselves to a standing position. The DOC confirmed that the staff should have used the lift to transfer the resident from the floor. Use of unsafe transferring devices or techniques can lead to further injury.

Sources: Investigation notes; Critical Incident Report (CIS); home's Safe Resident Handling policy (CARE6-010.06-LTC, August 31, 2016); resident's progress notes; interviews with RN, RPN, PSW and DOC.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Annual Minimum Data Set (MDS) assessment completed for a resident on an identified date in 2019, indicated that the resident required a specific level of assistance for one of the activities of daily living (ADLs). The care plan was not clear to indicate the identified level of assistance. The RAI Coordinator and the DOC confirmed that the care plan did not provide clear direction to staff related to the level of assistance for the identified ADL.

Sources: resident's care plan and MDS annual assessment; interview with RPN, PSW, RAI Coordinator and DOC.

Issued on this 11th day of December, 2020

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

Original report signed by the inspector.