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

Hamilton Service Area Office
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Northridge Long Term Care — Original Public Report

Report Issue Date July 14, 2022
Inspection Number 2022_1347_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
AXR Operating (National) LP, by its general partners

Long-Term Care Home and City
Northridge LTC, Oakville

Lead Inspector
Parminder Ghuman (706988)

Additional Inspector(s)
Emmy Hartmann (748)
Betty Jean Hendricken (740884)

Inspector Digital Signature
Parminder S Ghuman
Digitally signed by Parminder S Ghuman
Date: 2022.07.14 14:04:43 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 25, 26, 27, 31, June 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 2022

The following intake(s) were inspected:

- 000076-22 (Complaint) related to staffing shortage affecting care of residents.
- 012968-21 (Complaint) related to concerns regarding care of resident.

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC# 001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 19

During a tour of the home on May 25, 2022, around 1315 hours a closed window was observed in one home area that opened to the outdoors and was accessible to residents. At the time of the observation there were no residents in the vicinity, and the risk was lower as this window was in a hallway and as per staff there were no residents in this home area who were exit seeking or risk of flight. The window did not have a mechanism to prevent the window from opening more than 15 centimeters (cm) and could be opened fully to approximately 60 cm.

The Environmental Service Manager (ESM) mentioned that they would fix the window right away. This was also brought to the Executive Director's (ED) attention around 1345 hrs. The ED also mentioned that they would follow up right away. Around 1405 hrs that same day, the ED reported back that a safety mechanism had been installed to prevent the window from opening more than 15 cm. Follow up observation was done and the window was locked with a stopper and it did not open more than 15 cm.

Date Remedy Implemented: May 25, 2022

[706988]

WRITTEN NOTIFICATION [PLAN OF CARE]

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

Non-compliance with: LTCHA, 2007 s.6 (1)

The licensee has failed to ensure that there was a written plan for a resident which set out the planned care, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care for the resident related to an activity of daily living.

During observations of care, it was identified that the resident required the assistance of one person for an activity of daily living.

Staff identified that they assisted the resident with this task.

The registered dietitian (RD) identified that the resident required constant supervision and encouragement with this activity of daily living. The RD reviewed the resident's care plan, and identified there was no written plan for the assistance required.

The DOC acknowledged that there should have been a written plan of care for identifying the resident's level of assistance required.

The resident experienced a change in condition in the five months after they were admitted to the home. There may have been a risk that the resident did not get the assistance they required as there was no written plan of care related to a specific activity of daily living.

Sources: Observation of care on an identified date; resident's care plan; interviews with staff, RD, and DOC.
[748]

WRITTEN NOTIFICATION [PLAN OF CARE]

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

Non-compliance with: LTCHA, 2007 s.6 (1) c

The licensee has failed to ensure that there was a written plan of care for the resident that set out clear directions to staff and others who provided direct care to the resident regarding their one to one staffing.

During observations of care, it was identified that the resident had one to one staff implemented.

Multiple staff provided conflicting information about the role and care the one-to-one staff was to provide the resident.

The resident's plan of care did not set out clear directions related to the role of the one to one related to the care of the resident; and there was a risk of resident's care not being provided as required.

The DOC acknowledged that the care plan should have provided clear directions related to the resident's one to one staffing.

Sources: Observations of care on an identified date; resident's progress notes, and care plan; interviews with staff and the DOC.

[748]

WRITTEN NOTIFICATION [PLAN OF CARE]

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

Non-compliance with: FLTCA, 2021 s.6 (10) b

The licensee has failed to ensure that when a resident was reassessed, that their plan of care was revised when the resident's care needs changed.

The Physiotherapist's (PT) revised the level of assistance and transfer interventions for a resident.

During an observation of the resident, they were transferred as per the updated PT recommendations; however, the resident's plan of care for transfers was not updated to reflect the change.

Registered staff identified that the plan of care was not updated when the resident's care needs changed related to their transfer status.

There was a risk that the resident care related to transferring may not have been provided as required, when their plan of care was not updated when their care needs changed.

Sources: Observation on an identified date; resident's care plan, progress notes, assessments; interviews with PT, and registered staff.

[748]

WRITTEN NOTIFICATION [COOLING REQUIREMENTS]

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

Non-compliance with: O. Reg. 246/22 s. 23 (4)

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented on an identified date when the outside temperature forecasted by Environment and Climate Change Canada for Oakville was 31 degrees Celsius. The home's "Interdisciplinary Heat Response Plan" stated that shades, drapes, blinds or window coverings will be kept closed; and all windows were to be closed to reduce humidity and maximize the cooling effect in the home.

During an observation on an identified date, two rooms were identified to have both the window and drapes kept open; and one room was observed to have the drapes open. Temperatures were taken in the rooms and the temperatures were over 26 degrees Celsius.

One of the resident who resided in one of the rooms identified some discomfort related to the heat. Registered staff identified that the windows and drapes should have been closed.
The Executive Director acknowledged that the home's heat related illness prevention and management plan was not followed.

Residents may have been at risk for heat related illnesses as the home's heat plan was not followed.

Sources: Observation on an identified date; the home's "Interdisciplinary Heat Response Plan"; interviews with resident and the Executive Director.

[748]

WRITTEN NOTIFICATION [MEDICATION MANAGEMENT SYSTEM]

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

Non-compliance with: O. Reg. 79/10 s. 114 (2)

The licensee has failed to comply with medication administration and proper disposal of medications for a resident.

In accordance with O. Reg 79/10 s. 8 (1) (b), the licensee is required to ensure that there was a medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home must be complied with.

Specifically, staff did not comply with the home's Medication Administration and Medication Disposal policy.

On an identified date, staff did not follow the Medication Administration policy when a resident refused their medications. These medications were not disposed off as per MediSytem Disposal policy.

In an interview with the DOC, it was confirmed that that registered staff failed to follow the Medication Administration policy. Registered staff signed for the medication prior to the administration which was against the home's Medication Administration Policy. The DOC confirmed that the resident refused their medication on an identified date but the medications were signed in the electronic Medication Administration Record (eMAR) as administered which was also against home's Medication Administration Policy. The DOC also confirmed that the registered staff failed to follow the Medication Disposal policy. The registered staff failed to dispose of the refused medication into a pharmaceutical disposal bin as per the MediSytem Disposal policy.

There was a risk that the resident did not receive scheduled meds and refused medications were not disposed off as per the policy.

Sources: Medication Administration Policy, Policies & Procedures: Manual for MediSystem Serviced Homes, Progress notes, eMAR, Medication Incident and Interview with DOC.

[706988]

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The 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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.

- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.