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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 1, 2023

Inspection Number: 2023-1347-0003

Inspection Type:
Complaint
Critical Incident System

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

Long Term Care Home and City: Northridge, Oakville

Lead Inspector	**Inspector Digital Signature**
Parminder Ghuman (706988)	Parminder S Ghuman Digitally signed by Parminder S Ghuman Date: 2023.06.01 15:20:17 -04'00'

Additional Inspector(s)
Waseema Khan (741104)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 6, 11-14, 17-20, 24-26, 2023.

The following intake(s) were inspected:

- Intake: #00002558 - Critical Incident (CI) # 2862-000003-22 related to staff to resident neglect.
- Intake: #00007123 - CI # 2862-000031-22 related to fracture of resident.
- Intake: #00008243 - CI # 2862-000033-22 related to physical abuse to resident by staff.
- Intake: #00015050 - CI # 2862-000054-22 related to traumatic injury to arm.
- Intake: #00015970 - CI # 2862-000057-22 related to verbal abuse of resident by staff.
- Intake: #00016359 - CI # 2862-000059-22 related to Improper/incompetent care of resident by staff and concern related to transferring and resident care.
- Intake: #00016900 - CI # 2862-000060-22 related to Environmental Hazard - Failure/breakdown of major system - Fire sprinkler/standpipe system.
- Intake: #00018159 - CI # 2862-000002-23 related to allegation of improper/incompetent care of resident, concerns related to pain assessment/plan of care and late reporting.
- Intake: #00022993 – CI # 2862-000019-23 related to fall of resident resulting in fracture.
- Intake: #00015098 - Complaint related to Infection Prevention and Control.
- Intake: #00015862 - Complaint related to abusive conduct of staff.

The following intake(s) were completed:

- Intake: #00001337 - CI # 2862-000018-21 related to fall of resident resulting in hip fracture.
- Intake: #00007662 - CI # 2862-000027-22 related to fall of resident resulting in fracture.
- Intake: #00002130 - CI # 2862-000028-22 related to fall of resident resulting in fracture.
- Intake: #00014415 - CI # 2862-000051-22 related to fall of resident resulting in hip fracture.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care for a resident collaborated with each other in the development and implementation of the plan of care so that their care was integrated and consistent with each other related to falls.

Rationale and Summary
The resident had a written plan of care and assessments that indicated the resident was screened as high risk for falls. The plan of care specified the use of specific falls intervention.

On an identified date, inspector observed the resident was not using specific falls intervention. Staff checked the Point of Care (POC) documentation and verified that the resident had to use this specific fall intervention, but it was not communicated to them**.** During the interview the staff member verified that they were not aware that the resident had to use this specific fall intervention.

There is potential for the risk of harm to occur when staff does not collaborate with each other in the development and implementation of the plan of care.

Sources: Homes policy "Fall Prevention and Injury Reduction Program". Resident's plan of care, falls risk screen and falls risk assessment. Observation and interviews with staff.

[741104]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident was provided care as specified in the plan of care.

Rationale and Summary
The Resident's plan of care specified that all activities of daily living for personal care would be done while the resident was in bed.

Video surveillance of a specific date identified that the PSW's used a mechanical device to assist resident with personal care. Staff verified that the resident needs to be in bed for all activities of personal care. Assistant Director of Care (ADOC) acknowledged that staff did not follow the plan of care, related to personal care.

There is potential for the risk of harm to occur, when staff does not provide care as set out in the plan of care.

Sources: Video recording, resident progress notes, care plan, interviews with staff and ADOC.

[741104]

WRITTEN NOTIFICATION: Verbal abuse of resident by PSW

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Non-compliance with: FLTCA, 2021 s 24(1) Duty to protect
The licensee has failed to protect resident's from verbal abuse.

Section 2 (1) of the Ontario Regulations. 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Rationale and Summary
Video surveillance of a specific date identified staff entered a residents room. Resident's personal care item was on floor beside the bed. Staff was verbally repetitive with her words as seen on the video and they implied that the resident did it on purpose. ADOC acknowledged that the resident was verbally abused by staff.

Failure to protect the resident from verbal abuse, had the potential of risk to harm to occur which result in diminishing resident's sense of well-being, dignity or self-worth.

Sources: Video recording, resident progress notes, care plan, interviews with ADOC and DOC.

[741104]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Rationale and Summary

An allegation of abuse was reported on an identified date, in relation to an incident that occurred on this identified date. Staff documented the incident in the resident's electronic chart but failed to report this incident to the Registered Nurse and failed to report the suspected abuse to the Director. DOC acknowledged that the incident was reported late and confirmed that staff failed to follow the process for reporting certain matters to the Director immediately.

Not reporting suspected abuse immediately to the Director puts the residents at risk of harm for abuse.

Sources: CI # 2862-000033-22, Resident progress notes interview with DOC.

[706988]

WRITTEN NOTIFICATION: Pain assessments not completed every shift

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that the resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose when initial interventions were not effective.

Rationale and Summary
Resident was assessed by Medical Director (MD) for pain management and pain medication utilization.

On an identified date, a resident was experiencing pain with a pain scale of 9/10. Pain medication was administered for pain control. Resident continued to experience pain. A review of medication administration records directed staff to complete Pain assessment form in Point click care (PCC) every shift. It was noted that the Pain Assessment – v2 form in PCC was not completed every shift.

Interviews with DOC and ADOC verified that the pain assessment (long form) - under assessment tab was not completed, which was required to be completed every shift as ordered in MAR.

Sources: Home's policy titled "Pain Assessment and Symptom Management Program"
INDEX: CARE8- P10, modified April 4, 2022, resident Clinical records, interviews with ADOC and DOC.

[741104]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The licensee has failed to ensure that the Director was informed of resident’s significant change that required hospitalization within three business days after occurrence of the incident.

Rationale and Summary
On an identified date, the resident was transferred to hospital for issues related to their arm. This incident required medical interventions to treat the resident. A CIS report was submitted on a later date, exceeding the three business days from the date of the incident. The DOC & ADOC acknowledged that the CI was not submitted within three business days after the incident, when they were able to determine that this hospitalization has resulted in a significant change in resident's condition.

Sources: Clinical records of resident including progress notes, physician orders; interviews with staff, interview with DOC & ADOC; Critical Incident Report 2862-000054-22.

[706988]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

The licensee must comply with FLTCA, s. 102 (2) b.
Specifically, the licensee must:
1. Provide education and re-training for all PSWs, Registered Staff, Housekeeping staff, and leadership team on the home's use of personal protective equipment (PPE) policy.
2. Conduct more frequent auditing of PPE use for a minimum of two months until the home has no further concerns.
3. Document use of PPE education and re-training provided, including the date and the staff members who were provided the education and re-training.
4. The home must maintain a record of the education and use of PPE audits and actions taken based on audit results, for Long-Term Care Home (LTCH) Inspector review.

Grounds Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)
The licensee has failed to ensure that standards and protocols issued by the Director with respect to infection prevention and control were followed. Specifically, the home failed to follow proper personal protective equipment (PPE) requirements when providing care to a resident.

Rationale and Summary
Section 2 of the Minister's Directive, requires that licensee ensure that PPE requirements as set out in

the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units are followed. On a specified date, resident #002 was put on Droplet/Contact precautions for runny nose and cough. The resident was confirmed COVID positive by Polymerase Chain Reaction (PCR) test on a later date.

- Video surveillance of a specific date showed a staff member entering a resident's room to answer the phone. The staff was wearing mask and face shield but was not wearing gloves and gown. Staff assisted resident moving them on their wheelchair, staff was wearing a mask and face shield but was not wearing gloves and a gown.
- Digital Photograph #1 which was sent by DOC on a specified date, by email, was specific for a date and time. The picture depicts that the 1st staff providing care to the resident was wearing a mask and gloves but was not wearing a face shield and gown. The 2nd staff entering the room, was wearing a mask, face shield and gloves but was not wearing a gown.
- Digital Photograph #2 was sent by DOC on another date, by email, was specific for a date and time. The staff was offering meds to the resident, staff was not wearing gloves and gown.

IPAC Manager verified that the resident was on Droplet/Contact precautions and staff who did not wear PPE at the time of the incident was provided education for breaching the protocol. Interviews with the staff verified that they entered residents' room without wearing PPE.

By not wearing the appropriate PPE, and following infection prevention and control practices, there was an increased risk for the transmission of COVID-19 placing the health and safety of resident at risk.

Sources: Resident progress notes, Interviews with staff, IPAC Manager and record review of Video (PPE) Picture 01 and Picture 02 sent by DOC. IPAC Education, On- the- spot feedback and education document.

This order must be complied with by August 15, 2023.

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;
(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.