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
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Original Public Report

Report Issue Date: July 10, 2023	
Inspection Number: 2023-1347-0004	
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 Waseema Khan (741104)	**Inspector Digital Signature** Waseema Khan Digitally signed by Waseema Khan Date: 2023.07.17 09:36:16 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 8, 12, 14-16, 19- 21, 2023

The following intake(s) were inspected:

- Intake: #00020301 - Critical Incident(CI) #2862-000010-23 related to skin and wound care.
- Intake: #00084060 - Critical Incident (CI) #2862-000020-23 related to falls prevention and management.
- Intake: #00086135 -Complaint with concerns regarding care.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to the ensure rights of resident were fully respected and promoted within the meaning of the Personal Health Information Protection Act, 2004 and kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

Rationale and Summary
A resident's family member contacted Registered Practical Nurse (RPN) and requested the resident's progress notes. During the time of the request the resident was hospitalized and the RPN faxed progress to the family member. The family member was not the Substitute Decision Maker (SDM).

There was a breach of the privacy and confidentiality as per Personal Health Information Protection Act, 2004 (PHIPA) when personal health information was shared with a family member other than the SDM

Source : Resident progress notes, CI #2862-000010-23, licensee's investigation report and Interview with DOC.

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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)

The licensee failed to comply with their strategy to monitor resident, as per home's fall prevention and injury reduction program.

Rationale and Summary
In accordance with O. Reg 246/22, s.11 (1) (b),The policy directed prevention strategies to reduce or mitigate falls are in place to meet the needs of each resident.

A resident's plan of care had interventions which included the use of falls risk logo on the walker and below the memory box.

The resident had witnessed fall and was sent to the hospital with stable fractures . Falls risk screen was completed post fall, indicating resident was at high risk for falls.

The memory box and the walker did not have a falls risk logo as specified in the plan of care. A RPN and PSW both confirmed that the falls risk logo was not on the memory box and resident walker as required.

There was an increased risk, when falls risk logo is not placed as a strategy to reduce or mitigate falls for monitoring a resident at high risk of fall.

Source: Resident's clinical notes, plan of care, observation, licensee's " Fall Prevention and Injury Reduction Program", Interviews with RN and PSW.

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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using skin and wound care app that is specifically designed for skin and wound assessment.

Rationale and Summary
A skin impairment which had evolved was assessed by two staff members, however a skin and wound evaluation was not completed on point click care.

Failure to complete skin and wound evaluation, resulted in harm to the resident with delayed treatment of the residents skin impairment.

Source: Resident clinical notes, CI #2862-000010-23, licensee's investigation report, licensee's Skin and Wound Care Program and Interview with DOC and RPN.

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