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: August 1, 2024

Inspection Number: 2024-1347-0003

Inspection Type:
Complaint
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: Northridge, Oakville

Lead Inspector	**Inspector Digital Signature**
Daria Trzos (561)	Daria Trzos Digitally signed by Daria Trzos Date: 2024.08.07 10:07:39 -04'00'

Additional Inspector(s)
Indiana Dixon (000767)
Sarah Valente (000847)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15, 16, 17, 18, 19, 22, 2024.

The following intake(s) were inspected:

- Intake: #00114259 - Critical Incident (CI) 2862-000012-24 - related to a fall of a resident with injury.
- Intake: #00115580 - Complaint related to falls of a resident and maintenances services.
- Intake: #00115700 - CI 2862-000017-24 - related to injury of unknown cause.

- Intake: #00116640 - CI 2862-000021-24 - related to allegation of neglect of a resident.
- Intake: #00117068 - CI 2862-000022-24 - related to improper/incompetent treatment of a resident.
- Intake: #00117419 - Complaint related to neglect of a resident.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, related to transferring.

Rationale and Summary
The home submitted a Critical Incident Report (CIR), indicating that a resident sustained an injury. The resident's plan of care indicated that the resident required a specified device for transfers. This information was also displayed on the wall of the resident's bathroom.

Staff did not use the correct transferring device to transfer the resident which was confirmed by a personal support worker (PSW).

The Director of Care (DOC) acknowledged that the incorrect transferring device was used to transfer the resident and indicated that staff were expected to follow the resident's plan of care.

Sources: Review of resident's plan of care, investigation notes; observation; interviews with staff and the DOC.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 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.

The licensee has failed to ensure that a resident was not neglected by staff of the home.

Ontario Regulations 246/22, s. 7 states "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety

or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
The home submitted a CI report regarding an alleged incident of neglect against a resident. The CI report indicated that due to the incident the resident experienced a decline in their health status.

Records indicated that there was a decline in resident's health condition. A registered staff stated they assessed the resident after the incident and their assessment indicated a decline in the resident's health condition. They also stated that there was a delay in notifying the resident's Substitute Decision Maker (SDM) or physician, which resulted in delay of the resident receiving further assessment from the hospital care team. This was acknowledged by registered staff and the DOC.

Sources: Review of CI report, home's internal investigation notes, resident's progress notes; interview with staff and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Pursuant to s. 154 (3) of the FLTCHA, 2021, the licensee is vicariously liable to staff members failing to comply with section 28 (1) 1.

Rationale and Summary
An incident of improper care of a resident was not reported to the home's management team immediately by a staff member that observed the incident of the improper care. The home's policy "Mandatory Reporting of Resident Abuse or Neglect" (January 30th, 2024) directed staff to report any incident of improper care of a resident to the person in charge. They would then immediately report this to their legislative Authority. The CI was submitted to the Director once the management became aware of it.

Sources: Review of the CI, investigation notes, home's policy titled "Mandatory Reporting of Resident Abuse or Neglect" (January 30, 2024); interview with staff and the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe positioning devices or techniques when assisting a resident during transfer.

Rationale and Summary
PSW staff used unsafe positioning method during a transfer of a resident. The home's policy had specific direction related to positioning of residents during transfer which was not followed to ensure safety. This was confirmed by the DOC.

Using unsafe positioning of a resident placed them at an increased risk for harm.

Sources: Review of resident's health records, CI, investigation notes, home's policy "Safe Resident Handling" (March 31, 2024); interview with staff and the DOC.

WRITTEN NOTIFICATION: Maintenance services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

The licensee has failed to comply with the organized program of maintenance services when a resident's bed needed repair.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that there is an organized program for maintenance services to keep all equipment in the home in good repair and that it must be complied with.

Specifically, staff failed to comply with the policy "Maintenance Service Requests", dated September 30, 2022.

Rationale and Summary
The home's policy titled "Maintenance Service Requests", dated September 30, 2022, indicated that every unit Supervisor, Department Head, and clerical/administrative person was to ensure that all items requiring repair, were submitted (either manually or electronically) to the Maintenance Department for review. The request was to have name and position of requestor. Upon completing each maintenance service request (MSR), the maintenance person was to document on the MSR (either online or manually) the following information: action taken, materials used, completed by, hours of labour, notes and date of completion.

The Director received a concern related to a resident's bed which was not functioning. During the inspection it was identified that there were maintenance requests (MSRs) submitted for repair of a resident's bed. None of the MSRs included the person's name who submitted the request. Other identified requests did not have information of the actions that were taken, who completed the work or dates of the completion. The Environmental Services Manager (ESM) indicated that the work was completed; however, all the information required as indicated in the policy was not documented. The Executive Director (ED) confirmed that the home's policy was not followed.

Sources: Review of resident's progress notes, maintenance request logs, home's policy "Maintenance Service Requests" (September 30, 2022); interviews with staff, ESM and ED.

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was notified immediately upon becoming aware of the alleged incident of neglect against them.

Rationale and Summary
The home became aware of an allegation of neglect against a resident; however, the home did not notify the resident's SDM upon becoming aware of it. This was acknowledged by registered staff.

During an interview with the DOC, they indicated that staff should have ensured that the resident's SDM was notified immediately upon becoming aware of the alleged incident. This was also noted in the home's internal investigation notes.

Sources: Review of investigation notes, resident's progress notes, and interviews with staff and the DOC.