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: April 06, 2023	
Inspection Number: 2023-1355-0003	
Inspection Type: Follow up Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: West Oak Village, Oakville	
Lead Inspector Olive Nenzeko (C205)	**Inspector Digital Signature** Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2023.04.12 15:35:44 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 17, 21-24, 28, 2023, with February 23, 2023, conducted offsite and March 1-3, 6-8, 2023.

The following intake(s) were inspected:

• Intake: #00005322/CI#2870-000013-22 related to prevention of abuse and neglect
• Intake: #00015122 - High Priority - Follow-up to CO#001 from inspection #2022-1355-0002/ 00008663 regarding FLTCA, 2021, s. 24(1) Duty to protect, CDD: February 28, 2023
• Intake: #00017170/CI#2870-000041-22 - Falls prevention and management
• The following intake (s) were completed in this inspection: Intake #00002966/CI#2870-000007-21; Intake #00003040/CI#2870-000008-21; Intake #00003121/CI#2870-000013-21; Intake #00003657/CI#2870-000009-22; Intake #00005468/CI#2870-000012-22; Intake #00007755/CI#2870-000014-22; Intake: #00013803/CI#2870-000039-22 related to an injury with a significant change in condition.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #01 from Inspection #2022-1355-0002 related to FLTCA, 2021, s. 24 (1) inspected by Olive Nenzeko (C205)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

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 IPAC remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control program required under subsection 23(1) of the Act complied with any standard or protocol issued by the Director.

Rationale and summary
The IPAC Standard for Long-Term Care Homes, dated April 2022, stated under section 9.1 (e) that at minimum Additional Precautions shall include point-of-care signage indicating that enhanced IPAC control measures were in place.
Droplet Contact Precautions signage was posted on a resident's room door. The resident's written plan of care stated that contact precautions were required, but there was no documentation indicating that droplet precautions measures were required. The IPAC Lead confirmed that the resident required Contact Precautions and that the wrong signage was

posted. The wrong signage was removed and replaced with the correct signage.

There was no impact or risk to the resident because the signage posted was above what the resident required.

Sources: Observations, Interview with IPAC Lead, Resident's care plan

[C205]

Date Remedy Implemented: February 28, 2023

WRITTEN NOTIFICATION: Late Reporting

NC# 002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Rationale and Summary
A resident fell and sustained an injury, was sent to the hospital and returned to the LTC Home with a significant change in their health condition.
The LTC home was informed of the significant change in the resident's health condition. A Critical Incident System (CIS) Report # 2870-000041-22 was submitted to the Ministry of Long-Term Care (MLTC) seven days after they became aware of the significant change.

The DOC confirmed that the incident was not reported to the Director within one business day of becoming aware of the significant change in health condition.

There was no impact or risk related to the late submission of the CIS report to the Director.

Sources: Resident's progress notes**,** Critical Incident System (CIS) Report # 2870-000041-22, interview with DOC.

[C205]

WRITTEN NOTIFICATION: Duty to protect

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

The Licensee has failed to ensure a resident was protected from neglect by staff in the home.

Rationale and Summary
O.Reg 246/22 defines neglect as 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.

A resident's plan of care included interventions to manage their responsive behaviours. The resident had a fall, and it was identified that the interventions to address the resident's responsive behaviours had not been implemented at the time of the fall. A staff member admitted to not implementing the interventions and to falsifying documentation.
The ED stated that this incident was a case of neglect.

The pattern of inaction, specifically staff failing to implement interventions to mitigate risk of harm to themselves and other residents resulted in the resident not being found after they fell, and any potential injuries not being attended to.

Sources: CI# 2870-000013-22, resident's plan of care, investigation notes, interview with ED.

[C205]

COMPLIANCE ORDER CO #001 Responsive Behaviours

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

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

The licensee shall ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

Specifically, the licensee must:
1. Ensure that the staff member identified in the incident receives re-education on the home's expectations and process for implementing interventions related to the resident's responsive behaviours.
2. Ensure the identified resident's responsive behaviour interventions as outlined in their plan of care are implemented by completing daily audits during a two-week period to ensure the resident's plan of care is followed and that there is a written action plan in place if the audits identify any deficiencies. A copy of the audits must be kept in the home.
3. The home shall maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet indicating that the identified staff member completed the education.

Grounds
The Licensee has failed to ensure that strategies were developed and implemented to respond to a resident’s responsive behaviours.

Rationale and Summary
A resident had a history of responsive behaviours towards other residents and their plan of care for responsive behaviours included specific interventions to mitigate risk to other residents.

A staff member failed to implement specific interventions in the responsive behaviour plan of care which may have prevented the resident from falling and sustaining an injury.

The staff member admitted to not implementing specific interventions during which time the resident fell.

The DOC indicated that it was the home's expectation that staff implement interventions as directed by the plan of care.
The failure to implement strategies to manage the resident 's responsive behaviours resulted in significant impact to the resident.

Sources: Investigation notes, Resident's plan of care, interview with DOC

[C205]

This order must be complied with by May 12, 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.