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

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Original Public Report

Report Issue Date: June 12, 2023
Inspection Number: 2023-1355-0004
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	**Inspector Digital Signature**
Daria Trzos (561)	Daria Trzos Digitally signed by Daria Trzos Date: 2023.06.13 13:58:32 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24, 25, 29-31, 2023 and June 1, 2, 2023.
The inspection occurred offsite on the following date(s): May 26, 2023.

The following intake(s) were inspected:

- Intake: #00003527 (Critical Incident (CI): 2870-000002-22) - related to an injury of unknown cause
- Intake: #00003905 (CI: 2870-000022-22) - related to alleged abuse towards a resident by staff
- Intake: #00012152 (CI: 2870-000036-22) - related to alleged abuse towards a resident by staff
- Intake: #00085659 - High Priority - Follow-up (FU) to compliance order (CO) #001 from inspection #2023-1355-0003 regarding O. Reg. 246/22, s. 58 (4) (b), responsive behaviours, compliance due date: May 12, 2023

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1355-0003 related to O. Reg. 246/22, s. 58 (4) (b) inspected by Daria Trzos (561)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Implementation of Policy

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 48 (1) 2.

The licensee has failed to ensure that the skin and wound procedure for a resident that sustained an altered skin integrity was implemented in the home.

O. Reg. 79/10 s. 8. (1) (b) requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, and the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

Specifically, staff did not comply with the policy Long-Term Care (LTC) - New Skin Impairment/ New Wound Assessment.

Rationale and Summary
The home's policy New Skin Impairment/ New Wound Assessment (modified March 1, 2021), indicated that when a resident sustained a new skin and wound, the expectation was to obtain a treatment order and process the treatment order in electronic treatment administration record (eTAR). Furthermore, the staff were expected to initiate and or updated the plan of care with appropriate interventions.

A resident sustained an altered skin integrity in 2022. Registered staff indicated they had a standing order for this type of skin alteration, but they still needed to notify the physician to confirm the order.

Then, they were required to transcribe this order onto the eTAR. Furthermore, the staff were to update the care plan with the altered skin integrity and relevant interventions. When this resident sustained the altered skin integrity, the order was not obtained from the physician, it was not added to the eTAR and the written plan of care was not updated. The Regional Manager confirmed that the staff failed to follow the policy related to a new skin impairment.

Failing to follow a policy/procedure may have increased the risk of a negative outcome to the resident.

Sources: Review of resident's clinical records; home's policy "New Skin Impairment/ New Wound Assessment" (March 1, 2021); interview with staff and the Regional Manager.
[561]

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 the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary
The plan of care for a resident had a specific intervention in place related to incontinent products. PSW staff that provided direct care to the resident did not apply the specific intervention. They were aware of the contents of the plan of care related to the incontinent product intervention; however, they still failed to follow it.

Failing to provide care as indicated in the plan of care, increased the risk of a negative outcome to the resident.

Sources: Review of the CI; investigation notes; plan of care including care plan, progress notes and continence assessments; interview with the resident, staff and the Regional Manager.
[561]

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 that a resident was protected from abuse by anyone.

O. Reg 246/22 s. 2(1) contains the definitions of different types of abuse

Rationale and Summary
A resident reported an incident during provision of care. The resident sustained an altered skin integrity as a result. Investigation notes, resident's clinical records and interview with management staff confirmed the incident occurred and that the resident sustained an altered skin integrity as a result.

The home failed to ensure that a resident was protected from abuse by staff.

Sources: Review of the CI; review of investigation notes and resident's clinical records; interview with staff and the Regional Manager.
[561]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with the STOP approach under the Resident Non-Abuse program, while providing care to a resident.

Rationale and Summary
Staff of the home did not comply with the LTC-Resident Non-Abuse program which identified that all staff members who provide direct care to residents were to have mandatory orientation, annual training and policy review on the Resident Non-abuse program. This program also included the STOP approach, which stands for:
S - stop what you are doing
T - think of alternatives
O - observe the resident and environment for triggers
P - plan another approach.

A resident reported that PSWs while providing care to them did not stop when they were resisting. The investigation notes and interview with the Regional Manager confirmed that the staff failed to comply with their STOP procedure which resulted in the resident sustaining an altered skin integrity.

Failing to follow the home's STOP program increased the risk for a negative outcome to the resident.

Sources: Review of the CI; review of investigation notes, resident's clinical records, home's Resident Non-Abuse Program (effective August 31, 2016) including STOP approach; interview with staff and the Regional Manager.
[561]

WRITTEN NOTIFICATION: Training

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all the areas required under subsection 82 (7) of the Act.

O. Reg 246/22, s. 261 (1) 2. indicated that skin and wound care was one of the areas in which training shall be provided to all staff who provided direct care to residents.

Rationale and Summary
The Regional Manager provided documentation that only 50 Per cent (%) of direct care providers received training in skin and wound in 2022.

Failing to train staff in skin and wound program increases the risk of staff not having knowledge of procedures for altered skin integrity and places risk to residents.

Sources: Email confirmation; interview with Regional Manager.
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