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

London District
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Original Public Report

Report Issue Date: November 5, 2024

Inspection Number: 2024-1447-0005

Inspection Type:
Complaint
Critical Incident
Follow up

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: McGarrell Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24, 25, 28, 29, 31, 2024 and November 1, 2024

The following Follow Up Compliance Order (CO) intakes were inspected:

- Intake #00123674 – CO #001 from inspection 2024_1447_0004 related to FLTCA, 2021 – s. 6 (5). Plan of Care with Compliance Due Date (CDD) August 30, 2024
- Intake #00123675 – CO #002 from inspection 2024_1447_0004 related to FLTCA, 2021 – s. 6 (7). Plan of Care with Compliance Due Date (CDD) August 30, 2024
- Intake #00123668 – CO #003 from inspection 2024_1447_0004 related to FLTCA, 2021 – s. 24 (1). Duty to Protect with Compliance Due Date (CDD) September 6, 2024
- Intake #00123669 – CO #004 from inspection 2024_1447_0004 related to O. Reg. 246/22 – s. 52 (1) a. Staff Qualifications with Compliance Due Date (CDD) August 30, 2024

- Intake #00123673 – CO #005 from inspection 2024_1447_0004 related to O. Reg. 246/22 – s. 61 (4) b. Palliative Care with Compliance Due Date (CDD) August 30, 2024
- Intake #00123672 – CO #006 from inspection 2024_1447_0004 related to O. Reg. 246/22 – s. 140 (2). Administration of Drugs with Compliance Due Date (CDD) September 13, 2024
- Intake #00123670 – CO #007 from inspection 2024_1447_0004 related to O. Reg. 246/22 – s. 82 (2). Training with Compliance Due Date (CDD) September 13, 2024
- Intake #00123671 – CO #008 from inspection 2024_1447_0004 related to O. Reg. 246/22 – s. 278 (1) 1. Staff records with Compliance Due Date (CDD) August 30, 2024

The following Complaint intake was inspected:
- Intake #00124794 Anonymous complaint related to alleged abuse to residents by a resident

The following Critical Incident (CI) intakes were inspected:
- Intake #00123893 [CI #2964-000021-24] related to a resident fall with injury
- Intake #00124089 [CI #2964-000022-24] related to a hypoglycemic event and hospitalization
- Intake #00129083 [CI #2964-000028-24] related to a parainfluenza outbreak

The following intakes were completed in the Critical Incident Inspection:
- Intake #00122271 [CI #2964-000017-24] related to a resident fall with injury
- Intake #00122569 [CI #2964-000018-24] related to a resident fall with injury

Previously Issued Compliance Order(s)

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

Order #003 from Inspection #2024-1447-0004 related to FLTCA, 2021, s. 24 (1)
Order #004 from Inspection #2024-1447-0004 related to O. Reg. 246/22, s. 52 (1) (a)
Order #007 from Inspection #2024-1447-0004 related to FLTCA, 2021, s. 82 (2)
Order #008 from Inspection #2024-1447-0004 related to O. Reg. 246/22, s. 278 (1) 1.
Order #006 from Inspection #2024-1447-0004 related to O. Reg. 246/22, s. 140 (2)
Order #005 from Inspection #2024-1447-0004 related to O. Reg. 246/22, s. 61 (4) (b)
Order #001 from Inspection #2024-1447-0004 related to FLTCA, 2021, s. 6 (5)
Order #002 from Inspection #2024-1447-0004 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Palliative Care
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure staff used a monitoring device in accordance with the manufacturer's instructions.

Rationale and Summary
A resident was assessed in a particular condition by two Registered Nurses (RNs) and was sent to the hospital, where the resident was diagnosed with a medical condition. The RNs did not follow the manufacturer's instructions for the equipment that was used.

Failure to follow the instructions delayed the treatment for the resident and potentially led to an unnecessary hospital transfer.

Sources: Review of a CIS report, the resident's medical records, and interviews with an RN and the Director of Care (DOC).

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain.

The licensee has failed to comply with their pain management program.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure there is a pain management program to identify and manage pain in residents, and this program must be complied with.

Specifically, staff did not comply with the home's pain management program by not notifying the Physician and/or the Nurse Practitioner (NP) when a resident was experiencing a sudden onset of new pain.

Rationale and Summary
The RN did not call the Physician or Nurse Practitioner (NP) when the resident complained of a sudden onset of severe pain, but rather documented for the day shift to notify the Physician.

Staff failed to follow the home's pain management program and notify the Physician or NP of the resident's sudden onset of new pain, which delayed pain-alleviating interventions and potentially caused the resident's second fall.

Sources: Review of a CIS report, the home's "Pain Assessment and Management" procedure, the resident's health care records, and interviews with the DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 7.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
7. An incident of severe hypoglycemia or unresponsive hypoglycemia in respect of which a resident is taken to hospital.

The licensee has failed to ensure the Director was informed no later than one business day after an incident with transfer to hospital.

Rationale and Summary
A resident experienced an incident and was transferred to the hospital. The DOC notified the Director of the incident three business days later after learning of the incident from hospital records.

Sources: Review of a CIS report, and the DOC's meeting notes with an RN and an interview with the DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a) (iii)

Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia;

The licensee has failed to ensure a quarterly review of an incident was completed to identify patterns.

Rationale and Summary
A resident had an incident that was not included in the home's quarterly review. The DOC acknowledged this omission, which might have prevented the identification of a pattern of incidents.

Sources: Review of a CIS report, and the Pharmacy Report, and interviews with an RN and the DOC.