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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: February 15, 2024
Inspection Number: 2024-1464-0001
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: Arbour Heights, Kingston

Lead Inspector	Inspector Digital Signature
Erica McFadyen (740804)	Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2024.02.23 10:25:34 -05'00'

Additional Inspector(s) Kayla Debois (740792)

INSPECTION SUMMARY

TThe inspection occurred onsite on the following date(s): January 5, 8-9, 11-12, 15-18, 22-24, 2024

The following intake(s) were inspected:

- Intake: #00100022 - CIS# 2982-000035-23- episode of resident choking
- Intake: #00100427 - CIS# 2982-000036-23- Alleged staff-to-resident abuse
- Intake: #00100638 - Follow-up #: 1 - O. Reg. 246/22 - s. 55 (2) (b) (iv) regarding weekly assessments of resident wounds

- Intake: #00100639 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) regarding resident wound care plan of care
- Intake: #00102235 Complaint about resident care
- Intake: #00102432 - CIS# 2982-000040-23 unwitnessed fall resulting in transfer to hospital
- Intake: #00104108 Complaint alleging neglect of a resident
- Intake: #00104406 CIS# 2982-000043-23 alleged staff-to-resident abuse
- Intake: #00104827 complaint regarding the care of a resident

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1464-0007 related to FLTCA, 2021, s. 6 (7) inspected by Erica McFadyen (740804)

Order #002 from Inspection #2023-1464-0007 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Erica McFadyen (740804)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The Licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
In an interview with an Registered Practical Nurse (RPN) it was stated that a Personal Support Worker (PSW) student alleged that a PSW had abused during a meal time on a specified date. The RPN stated that they attempted to call the on-call manager

for guidance but were unable to reach the on-call manager. The RPN stated that they left a report for the Registered Nurse (RN) at the conclusion of their shift regarding the incident. In an interview with the RN they were unable to recall their conversation with the on-call manager.

CIS Report #2982-000036-23 indicated that the alleged abuse occurred on a specified date at a specified time and that the incident was submitted to the Director approximately 24 hours later. In an interview with the Director of Care (DOC) it was stated that the Director was not immediately notified of the alleged abuse.

When the Director is not immediately notified of incidents of alleged staff-to-resident abuse they may not be promptly investigated within the long-term care home.

Sources:
Interview with the RPN, RN, and DOC. Review of CIS Report #2982-000036-23. [740804]

The Licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
In an interview with a PSW it was stated that they witnessed physical and verbal abuse from their PSW coworker towards a resident during evening care on a specified date. The PSW who witnessed the alleged abuse stated that they called and made a formal complaint of abuse at approximately midnight on the same day to the RN.

In an interview with the RN it was stated that the alleged abuse was reported to them by the PSW at approximately midnight on a specified date. In an interview with the RN it was stated that the after-hours reporting line was not called and that the alleged abuse was not reported to the Director immediately.

In an interview with the DOC it was stated that the incident of alleged abuse was verbally reported to them approximately seven hours after it was reported to the RN. It was stated that the after-hours line was not called at the time of the incident and the Director was not notified until the DOC called after being notified by the RN.

A review of CIS report #2982-000043-23 indicated that the alleged staff-to-resident abuse occurred on a specified date and that the DOC was notified of the alleged abuse the next day. After Hours Infoline #20976 indicated the Director was notified of the alleged abuse by the DOC the day following the alleged abuse.

The risk of alleged abuse not being reported to the Director immediately is that incidents of alleged staff-to-resident abuse may not be promptly investigated within the long-term care home.

Sources:
Interviews with a PSW, RN, and DOC. Review of CIS report #2982-000043-23 and After Hours Infoline #20976

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WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the documentation for the Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) for resident #001 was completed.

Rationale and Summary:
Review of the BSO-DOS sheets from specified dates over a four day period for a resident indicated that documentation was not completed on a specified date from 2030 to 2300 hours and an additional specified date from 0700 to 2300 hours.

Review of the BSO-DOS sheets from specified dates over a five day period for the resident, indicated that documentation was not completed on a specified date from 0700 to 0800 hours and 1430 to 2300 hours, and there was no documentation for a full specified date within that five day period.

During an interview with the DOC, they stated that both PSW's and nurses' are to complete the BSO-DOS documentation. A PSW and the DOC acknowledged that it is the expectation that BSO-DOS sheets be filled out completely.

Failing to ensure resident's behaviours are documented can increase the risk of uncertainty whether the behaviour was present or not.

Sources:
BSO-DOS documentation for the resident, interview with a PSW and DOC.

[740792]

The licensee has failed to ensure that the documentation of a resident's activities of daily living (ADL's) related to personal hygiene and dressing were documented.

Rationale and Summary:
A resident's care plan on PointClickCare (PCC), initiated on a specified date, stated that they require limited assistance with one staff member to complete personal hygiene and dressing activity.

Upon review of Point of Care (POC) documentation, there was no documentation for ADL's-dressing and personal hygiene completed during the day shift of a specified date for the resident. Upon review of the progress notes on PCC and multidisciplinary notes, there was no documentation of personal hygiene or dressing being completed for the resident on that date during the day shift. Progress notes indicated that the resident had care completed during the night shift, at 0430 hours.

In separate interviews with PSW #106, PSW #111 and the DOC, they stated care should be done on the day shift even if the previous shift communicated that the care was done during the night shift. An Registered Practical Nurse (RPN) stated the resident is to receive morning care after breakfast, and if the PSW is unable to complete the care because the resident is refusing, the PSW's will reattempt later. If still unsuccessful, the RPN on the unit will attempt the care.

PSW #111, PSW #108, PSW #113, PSW #114, and PSW #115 were unsure if the resident received assistance related to personal hygiene and dressing on the specified date during the day shift. PSW #113, who was the resident's one to one

that day, stated if a staff member attempted or completed care, they would have documented this in the multidisciplinary notes. The RPN stated they can't remember if the resident got their care completed during the day shift on the specified date, but if they didn't document it being done in the progress notes, they themselves wouldn't have done the care.

The DOC acknowledged it is the expectation that staff document the care they provide to residents.

Failing to ensure resident's care is documented can increase the risk of uncertainty whether the care was provided or not.

Sources:
Resident care plan, progress notes, POC documentation, and multidisciplinary notes documentation, review of video footage from the resident's camera in the room, interviews with PSW #106, PSW #108, PSW #111, PSW #113, PSW #114, PSW #115, the RPN and the DOC.

[740792]

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.

The licensee has failed to ensure that an immediate report to the Director regarding improper or incompetent treatment or care of a resident, resulting in harm or a risk of harm to the resident was completed.

Rationale and Summary:
During the night shift of a specified date a resident was offered a regular texture meal by a PSW. At the time the resident was on a mechanically altered diet texture. The resident ate some of the regular texture meal and then began choking. The RPN provided abdominal thrusts to the resident, and they were able to dislodge the piece of food, returning to their baseline status. This incident was reported to the Director during the following day shift.

During an interview with the RN, they stated they were the charge nurse on that night and were responsible for reporting to the Director. They stated they were unsure if this incident needed to be reported to the Director immediately. In an interview with the DOC, they acknowledged that this incident was reported late and should have been reported immediately.

Not reporting critical incidents immediately to the Director can delay the investigation and response time of the home.

Sources:
Resident progress notes and care plan in PCC, interview with the RN and DOC.

[740792]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee failed to comply with their written procedure related to nutritional care and hydration of residents.

In accordance with O. Reg. 246 / 22, s. 11 (1) b, the licensee is required to ensure that their written policy related to nutritional care and hydration of residents is complied with.

Specifically, staff did not comply with the LTC-Nutritional Care and Hydration policy (reviewed March 31, 2023): staff always confirm the resident's texture and fluid consistency requirements before the resident receives any food or fluid.

Summary and Rationale:
On a specified date at a specified time, Inspector observed a PSW in a specified resident hallway offering between meal beverages. A selection of drinks were noted on the cart, along with two thickened boxes of juice. Inspector observed the PSW provide fluids to five different residents in their rooms. The PSW asked the residents

what they would like to drink, poured the drink, and then provided it to the resident. The PSW was not observed to be referencing any information related to residents' diets before preparing the drinks for the residents.

During an interview with this PSW they stated they can check residents' diet and fluid requirements with the MealSuite app on the tablet. The PSW acknowledged that they did not have a tablet with them when completing the morning beverage service, stating they remember a residents' dietary requirements as they have been working on this unit for a few weeks.

In separate interviews with an RPN, the Registered Dietician (RD), and the DOC, they stated when providing drink/snack service, staff should be using the MealSuite app on the tablet to ensure they are giving the correct diet and drink texture.

During an interview with the DOC, they confirmed that the PSW was not following policy for checking resident's fluid requirements during the morning beverage service.

Not confirming the resident's diet/fluid types before serving them food or drinks puts them at risk of being given the incorrect food texture or fluid consistency.

Sources:
Observation of the PSW, Nutritional Care and Hydration Policy (CARE7-010.05) revised March 31, 2023, interview with the PSW, RPN, RD, and DOC.

[740792]

WRITTEN NOTIFICATION: Residents' drug regimes

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee has failed to ensure that when a resident was taking a psychotropic drug, there was monitoring and documentation of their response and the effectiveness of the drug appropriate to the risk level of the drug.

Rationale and Summary:
A resident was prescribed a psychotropic drug on a specified date for physical agitation / aggression. An antipsychotic medication monitoring tool was initiated on that date and was to be completed every shift for two weeks.

Upon review of the antipsychotic medication monitoring tool, there was no documentation completed for several shifts over a period of ten days.

The resident was prescribed a different psychotropic drug on a different specified date for responsive behaviours and aggression with care. An antipsychotic medication monitoring tool was initiated on the day it was prescribed to be completed every shift for two weeks.

Upon review of the antipsychotic medication monitoring tool, there was no documentation completed for the several shifts over five days.

During an interview with an RPN, they stated the antipsychotic tool is implemented when starting a resident on antipsychotic medication but documentation for this tool is not always being done. In an interview with the DOC, they stated the nurse on shift would complete the documentation and the documentation should be fully completed.

Failing to ensure a resident's response to medications are documented can increase the risk of uncertainty whether the medication is effective or not.

Sources:
The resident's antipsychotic monitoring tool, interview with the RPN and DOC.

[740792]

WRITTEN NOTIFICATION: Resident records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record is kept up to date at all times.

Rationale and Summary:
Review of the resident's POC documentation, completed by PSW #110, on a

specified date states ADL's-dressing and personal hygiene were completed at a specified time with one person physical assist. Progress note documentation on PCC indicated that on a specified date, a PSW reported the resident refused all evening care. Multidisciplinary notes on that date stated multiple staff tried to redirect the resident for evening care with no result. Upon review of the video camera footage in the resident's room from that time period, the resident went to bed in day clothes.

During an interview with PSW #110, they stated they couldn't remember if they were able to provide dressing care for the resident on that date. They stated they likely input incorrect documentation.

Review of the resident's POC documentation, documented by PSW #108, on the day shift a different specified date indicated ADL's-dressing and personal hygiene was completed at a specified time with one person physical assist. Progress note documentation on PCC stated that the resident allowed minimal care to be done, with different staff members trying multiple times to assist the resident with changing their pants. Review of the multidisciplinary notes for the resident indicated that at a specified time on that date, they refused care after being asked multiple times. Upon review of the video camera footage from the resident's room from that date for a specified time, the resident was wearing pajama pants for the duration of the footage. Specifically, at a specified time during the day, the resident was still in pajamas.

During an interview with PSW #108, they stated they have never provided care to the resident, but it's likely that another staff member told them they completed the care. They stated the resident was assigned to them that day, so they would document the care that was provided even if they didn't complete the care themselves.

During separate interviews with PSW #111 and an RPN, they stated that around that time, there was some confusion over who was to be documenting the care provided to the resident, as they also had a one to one staff member assigned to them at this time.

During an interview with the DOC, they stated the staff are expected to document care appropriately and the person who provided the care is responsible for documenting the care. Staff should not be documenting on care that they did not provide.

The risk of incorrect documentation within POC is that it may result in a clinical record that does not accurately reflect the care that was provided.

Sources:
The resident's progress notes, POC documentation, and multidisciplinary notes documentation, review of video footage from the resident's camera in the room, interviews with PSW #108, PSW #110, PSW #111, the RPN, and the DOC.

[740792]

COMPLIANCE ORDER CO #001 When reassessment, revision is required

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

1) Ensure that registered staff are provided training on the process of notifying the Registered Dietitian when a resident has a choking incident, when a Speech Language Pathologist recommendation is received and who is responsible for updating the plan of care when there is a diet change.
2) Maintain documentation of the education, including the names of the staff, their designation, and the date the training was provided.
3) Review the plan of care for all residents on the specified unit who are at high nutritional risk to ensure that the correct diet texture is identified.
4) Ensure that PSW's and registered staff comply with the written plan of care for residents on the specified unit who are at high nutritional risk.

In ensuring the requirements under step (4) are met, the licensee shall:
5) Complete a weekly audit of all residents on the specified unit who are at high nutritional risk to ensure that the correct diet texture is being provided as specified in the plan of care. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.
6) Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings, and any corrective actions taken.

Grounds
The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary:

The resident had a history of choking episodes and was identified as a high nutritional risk. A speech language pathologist (SLP) assessment was completed on a specified date due to frequent choking. They recommended the resident have a specified mechanically altered died, and they would be reassessed at a later date. On a specified date approximately a month later, a follow up SLP assessment was completed, and recommended the resident receive a different mechanically altered diet, specifically with no bread.

On a specified date, during the night shift, the resident was provided bread by a PSW. The resident ate some of the bread and then began choking. An RPN provided abdominal thrusts to the resident, and they were able to clear the food, returning to their baseline status.

During an interview with the PSW, they stated that they did not check the resident's diet before providing them bread and acknowledged that they provided the resident with the wrong diet texture. In an interview with the DOC, they stated that the PSW could have checked the resident's care plan, Kardex, MealSuite application on the tablet, or ask a registered staff member to confirm the resident's diet texture. They confirmed that the PSW who provided the food gave the resident the incorrect diet texture, placing the resident at risk of harm.

At the time of the choking incident, the resident's care plan focus for eating indicated they were on a specified diet type as inputted by an RPN, while the nutritional risk focus indicated they were on a different specified diet type as inputted by the Registered Dietitian (RD).

During an interview with the RPN, they stated the nurse on the unit is to update the care plan when there is a change in diet, but this doesn't always happen. In an interview with a different RPN, they stated they do not update the care plan when

there is a diet change, and presume that it is the RD's responsibility. The RD confirmed they update the care plan with diet changes, but have seen nurses also do this.

A referral was sent to the RD following the choking incident by the DOC, and on the next day, the RD ordered the resident to have a mechanically altered diet, specifically with no bread, as per the SLP recommendation.

The resident was sent to the hospital for assessment five days after the choking episode for an unrelated circumstance. The hospital discharge summary indicated the resident's hospital diagnosis was pneumonia and dysphagia. The resident was sent again to the hospital for assessment shortly after for altered level of consciousness and was diagnosed with aspiration pneumonia. The resident was admitted for palliative care and passed away while in the hospital.

During an interview with the RD, they stated when an SLP assessment is done, the nurse on duty should notify them so they are aware. They further indicated that they can then review any recommendations and provide new dietary orders and update the care plan as needed. The RD stated they were not made aware of the SLP assessment completed for 19 days. In an interview with the DOC, they acknowledged that there was a large gap between the date the SLP recommendation was provided and when the RD was notified, stating the RD was not notified in a timely manner.

The RD and the DOC acknowledged that two different diet textures in the resident's care plan could be confusing to staff. The DOC acknowledged that the care plan was not revised appropriately.

Not altering the resident's plan of care related to diet texture correctly and within an

appropriate time period places residents at an increased risk of harm.

Sources:
The resident's care plan on PCC, progress notes on PCC, risk management report on PCC, SLP assessment's and hospital discharge summaries, interviews with PSW, RPN, RPN, RD, and DOC.

[740792]

This order must be complied with by March 28, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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

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.