Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 5, 2021	2021_598570_0022	001294-21, 005119-21, 007409-21, 007864-21, 009739-21, 014905-21, 014979-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Bay Ridges
900 Sandy Beach Road Pickering ON L1W 1Z4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 1, 2 and 3, 2021.

The following intakes were inspected in this Critical Incident System (CIS) Inspection:
Log #014979-21, related to a fall incident;
Log #014905-21, related to a fall incident;
Log #007409-21, related to a fall incident.

The following intakes were completed in the CIS Inspection: Logs # 009739-21, # 005119-21, # 001294-21, and # 007864-21, were related to falls.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), IPAC Manager, Registered Nurse (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

A critical incident system (CIS) report was submitted to the Director for a fall incident that resulted in an injury for which the resident was transferred to hospital and resulted in a significant change in condition. The CIS report indicated that PSW #102 did not utilize the required device to transfer resident #001 resulting in an injury to the resident.

Resident #001's plan of care directed that the resident required support for transfers and required the use of a specified device for transfers.

Interviews with PSWs #107, #108 and RPNs #109, #112 and PT #110, revealed that resident #001 required the use of a specified device for transfers. PSWs #107, #108 and RPN #112, indicated that PSW #102 did not ask for help to assist with resident's transfer.

Interview with the Director of Care (DOC), indicated that PSW #102 did not follow the plan of care related to transfer status of resident #001 and that resulted in unsafe transfer that led to the resident's fall and the resident sustained an injury.

By not following resident #001's transfer status has led to unsafe transfer that resulted in an injury to the resident.

Sources: CIS report, internal investigation notes, interviews with PSWs #107, #108, RPNs #109, #112. PT #110 and the DOC. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 5th day of November, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.