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
Jan 14, 2022	2021_846665_0006	015252-21, 015277-21, 015984-21	Complaint

Licensee/Titulaire de permis

Toronto Aged Men's and Women's Homes
55 Belmont Street Toronto ON M5R 1R1

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

Belmont House
55 Belmont Street Toronto ON M5R 1R1

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

JOY IERACI (665), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 26, 27, 28, 29, November 1, 2, 3, 4, 5 and 8, 2021.

The following intakes were completed in this complaint inspection:
- Log #015984-21 related to neglect and;
- Logs #015277-21 and #015252-21, CIS #2985-000005-21 related to transfers.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physician, Assistant Director of Care (ADOC)/Infection Prevention and Control (IPAC) Lead, Quality and Education Coordinator, Nursing Supervisor (NS), Dietary Supervisor (DS), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Health Care Aides (HCAs), Physiotherapy Aide (PA), Dietary Aide (DA), Housekeeping Aides (HAs) and complainants.

During the course of the inspection, the inspectors conducted observations in the provision of care and services to residents, reviewed clinical records, training records and pertinent policies.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 VPC(s)
1 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 devices and techniques when assisting residents #001, #007 and #005.

The Ministry of Long Term Care (MLTC) received a complaint regarding care concerns

and the home submitted a critical incident report, regarding an injury resident #001 sustained requiring a transfer to hospital. The complainant had concerns that the injury was caused during resident #001's transfers.

Resident #001's care plan indicated that the resident required two person assistance for transferring and toileting using a mechanical lift.

The home's investigation notes documented that the day prior to resident #001's transfer to hospital, PSWs #115 and #135 toileted resident #001 with a mechanical lift. The PSWs left the resident seated on the toilet on their own and returned few minutes later.

PSW #115 told the inspector that resident #001 was transferred with a mechanical lift. They transferred the resident twice using an identified sling "Y". When the resident was toileted, they and PSW #135 left the resident alone seated on the toilet with the sling attached to the mechanical lift so they could attend to other residents. PSW #115 indicated the sling was not detached from the mechanical lift as the resident was not able to sit on the toilet without support. The PSW told the inspector that this had been a practice in the home and had been leaving residents on their own when toileted, with the sling attached to the mechanical lift.

PSWs #118, #119, #126 and #104 indicated they used an identified sling "X", and PSWs #128 and #115 used the identified sling "Y" for resident #001's transfers, instead of the assessed sling "Z" as per the plan of care.

DOC #100 confirmed that staff did not use the assessed sling "Z" for resident #001's transfers, the sling size should have been included in the resident's care plan, resident #001 was not to be left alone while seated on the toilet for safety, and it was best practice and the home's policy that staff detach the sling from the mechanical lift when resident #001 was seated on the toilet. The DOC acknowledged that staff did not use safe transferring devices and techniques when assisting resident #001.

Sources: Review of resident #001's clinical records, CIS #2985-000005-21 and interviews with DOC #100, PSWs #115, #118, #119, #126, #104 and other staff. [s. 36.]

2. As a result of non-compliance identified for resident #001, the sample was expanded to residents #007 and #005.

Resident #007 was a new admission to the home on an identified date.

The home's policy titled, Resident Safe Handling-Minimal Lift Policy, directed staff to assess each resident for the most appropriate lift/transfer method within 24 hours of admission. The assessment information and intervention(s) were to be documented in the resident's care plan and progress notes. The appropriate size sling was based on the size of the resident when mechanical lifts were used. Another policy titled, Slings-Use of and Sanitization, directed staff to assess size and type of sling to be used on each resident by measuring the resident using a sling measuring tape and determining the purpose of the sling (transfer or hygiene). The policy provided instructions on using the sizing guide tape for slings. The home also used another Size Guide to assess the appropriate size sling for residents based on weight.

Review of the resident’s Admission Assessment and Care Plan, showed the resident’s transfer status including the assessed sling size and type was not documented. A progress note on admission day, documented the resident was transferred with a mechanical lift, but did not include the assessed sling size and type.

RPN #132 and RN #116 indicated that the physiotherapist (PT) conducted the transfer assessment for new residents in collaboration with the registered staff. Both stated that the PSWs assessed the type and size of sling to be used for mechanical lift transfers. The staff were not aware of the home’s Size Guide for slings and the sizing guide tape. RPN #132 and RN #116 acknowledged that resident #007's transfer assessment had not been completed as per the home's policy.

PT #117 indicated that they conduct an initial assessment which included a transfer assessment in collaboration with the direct care staff within seven days of any new admission. The nursing staff were responsible for ongoing transfer and sling assessments and would get involved in the re-assessment when requested by the nursing staff.

During observations conducted on two consecutive days, PSWs #119, #126 and #104 used an identified sling "X", to transfer the resident onto the toilet with a mechanical lift. The following day, it was observed that the sling was attached to the mechanical lift while the resident was seated on the toilet.

DOC #100 indicated that for new resident admissions, staff reviews clinical records from Home and Community Care Support Services (HCCSS) as part of the residents' transfer assessment. The HCCSS' clinical records had documentation of resident #007's weight.

The DOC verified that based on the resident's weight and the Size Guide for slings, staff were to have used an identified sling "Y" instead of sling "X" for resident #007's transfers. The DOC indicated that staff should have detached the sling from the mechanical lift when resident #007 was seated on the toilet, as it was best practice and the home's policy. The DOC acknowledged that the home did not use safe transferring devices and techniques when assisting resident #007.

Sources: Observations on two identified dates; record review of Resident Safe Handling-Minimal Lift Policy, V2, revised date of July 2021; Slings - Use of and Sanitization Policy, V2, revised date of August 2021, Size Guide for slings, resident #007's clinical records and interviews with DOC #100, RN #116, RPN #132, PSW #119, and other staff. [s. 36.]

3. Review of resident #005's care plan, indicated that the resident was transferred with a mechanical lift using an identified sling "X".

Observations conducted on two consecutive days, revealed that PSWs #120 with #118 and #126 with #127 transferred resident #005 from their wheelchair to bed with a mechanical lift and used sling "X". The top of the sling extended approximately one foot past the resident's head in both observations. On the second day of observation, Inspector #665 observed another identified sling "Y" hanging on the resident's door. PSW #126 informed the inspector that they were not aware that sling "Y" was in the room and that both the "X" and "Y" slings were used for resident #005's transfers.

PSW #126 indicated that the registered staff were responsible for the sling assessments which included measuring the residents for the appropriate sling size, and was documented in the care plan. The PSW was not aware of the home's Size Guide for slings and the sizing guide tape.

RPN #132 and RN #116 indicated that PSWs assessed the type and size of sling to be used for mechanical lift transfers. They were not aware of the home's Size Guide for slings and the sizing guide tape.

Review of resident #005's weights documented their current weight at the time of the inspection. According to the home's Size Guide, an identified sling "Z" was to have been used for the resident.

DOC #100 indicated that it was the responsibility of the PSWs to conduct the sling assessment and that the sizing guide tape was available in the resident home areas for

both PSWs and registered staff to measure residents for the sling assessment. The DOC reviewed resident #005's weight and the Size Guide, and acknowledged that staff should have used sling "Z" for transfers. They also informed the inspector that sling "X" used during the inspector's observations, was too big for the resident as the sling should not have extended past the resident's head. The DOC acknowledged that staff did not use safe transferring devices and techniques when assisting resident #005.

Sources: Observations on two identified dates, review of resident #005's clinical records, review of Slings - Use of and Sanitization Policy, V2, revised date of August 2021, Size Guide for slings and interviews with DOC #100, RN #116, RPN #132, PSWs #126, 118, #127 and other staff. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints concerning the care of residents #001 and #002 were immediately forwarded to the Director.

A written complaint was sent to the home related to care concerns for resident #001.

DOC #100 acknowledged that the written complaint was not forwarded to the Director.

Sources: Review of resident #001's clinical records and interview with DOC #100. [s. 22. (1)]

2. A complaint was reported to the MLTC related to the lack of action taken when resident #002 experienced a change in health status.

A written complaint was sent to the home related to care concerns for resident #002.

DOC #100 acknowledged that the written complaint related to the care of resident #002 was not immediately forwarded to the Director and stated that it was missed.

Sources: Review of resident #002’s clinical records and interview with DOC #100. [s. 22. (1)]

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 every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the home's IPAC program.

During observations in resident home areas, the following were observed:
1. October 26, 2021, at 1143 hours and 1205 hours - Housekeeping Aides #125 and #103 were cleaning resident rooms and were double gloved;
2. October 26, 2021 at 1157 hours- PSW #101's mask was not covering their nose in the dining room with other residents and staff present;
3. October 26, 2021 at 1200 hours - RN #102 had their mask under their chin and had a beverage in the nursing station while working in front of the computer;
4. November 1, 2021 at 1205 hours - PSW #113 did not perform hand hygiene after handling dirty dishes and proceeded to serve drinks and food to residents in the dining room and;
5. November 1 and 2, 2021 at 1035 hours and 1420 hours - Dietary Aide #134 and Staff #114 did not assist residents with hand hygiene before snacks were provided.

The home's policy titled V4-Infection Prevention and Control, documented the home followed the Four Moments of Hand Hygiene and that hand washing was performed before meals and breaks. Additionally, the home followed Public Health Ontario's IPAC guidance as part of their IPAC program. The document titled Health Care Huddles: IPAC Checkpoints, indicated not to layer personal protective equipment (PPE) (do not double glove or double mask). A memo to all staff dated September 1, 2021, reminded staff of the home's PPE principles which included: to wear masks properly, masks are to always cover the nose and mouth when in the home; during breaks, staff may remove their mask; and clean your hands for 15 seconds following the four moments of hand hygiene.

HA #103, PSWs #101 and #113 confirmed that they did not follow the home's IPAC practices. PSW #113 indicated that hand hygiene for residents who required assistance was not done before meals. DA #134 and Staff #114 also confirmed that they did not assist residents with hand hygiene before snacks were provided.

ADOC/IPAC Lead #108 told the inspector that staff were not allowed to eat and drink in the nursing station, which had been an IPAC practice prior to the pandemic. They acknowledged that staff #101, #102, #103, #113, #114, #125 and #134 did not participate in the implementation of the home's IPAC program.

Sources: Observations on October 26, 2021 and November 1 and 2, 2021, record review of Policy V4-Infection Prevention and Control, revised April 2021, Public Health Ontario Health Care Huddles: IPAC Checkpoints and COVID-19 PPE Principles Memo dated September 1, 2021, interviews with staff #101, #102, #103, #113, #114, #134 and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint made to the licensee concerning the care of resident #002, where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.

A complaint was reported to the MLTC related to the lack of action taken when resident #002 experienced a change in health status.

Record review indicated a written complaint was sent to the home related to care concerns for resident #002 and the home acknowledged receipt of the written complaint three days later.

DOC #100 stated that an investigation had immediately commenced but was not able to provide proof of this. They acknowledged that an investigation did not commence immediately, and a response was not provided to the complaint within 10 business days.

Sources: Review of resident #002’s clinical records and interview with DOC #100. [s. 101. (1) 1.]

2. The licensee has failed to ensure that every written complaint made to the licensee concerning the care of resident #001 had a response to the person who made the complaint, indicating, what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

The home received a written complaint, regarding care concerns of resident #001. The home acknowledged receipt of the complaint the following day.

Review of the home's investigation notes and complaint form did not have documentation on the home's response to the complainant.

DOC #100 confirmed that the home did provide a response to to the complainant after the home's investigation.

Sources: Review of written complaint, complaint form and investigation notes for resident #001, and interview with DOC #100. [s. 101. (1) 3.]

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

Issued on this 28th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JOY IERACI (665), JULIEANN HING (649)
Inspection No. / No de l’inspection :	2021_846665_0006
Log No. / No de registre :	015252-21, 015277-21, 015984-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 14, 2022
Licensee / Titulaire de permis :	Toronto Aged Men's and Women's Homes 55 Belmont Street, Toronto, ON, M5R-1R1
LTC Home / Foyer de SLD :	Belmont House 55 Belmont Street, Toronto, ON, M5R-1R1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Maria Elias

To Toronto Aged Men's and Women's Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must comply with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that all residents using a mechanical lift, receive a transfer assessment, are assessed for the appropriate size sling as per the home's policy and have the sling size and type documented in their plan of care.

2. Ensure that residents #005 and #007 are transferred using the assessed sling size as per the plan of care.

3. Ensure that a transfer assessment is completed within 24 hours for newly admitted residents and is documented in the plan of care in accordance with the home's policy.

4. Ensure all direct care staff receive re-training on the home's transfer and sling policies and are aware of their responsibilities in the process.

5. Maintain a written record of the training provided in the home. The written record must include the date of the training, name of the person who provided the training and names of staff who attended the training.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting residents #001, #007 and #005.

The Ministry of Long Term Care (MLTC) received a complaint regarding care

concerns and the home submitted a critical incident report, regarding an injury resident #001 sustained requiring a transfer to hospital. The complainant had concerns that the injury was caused during resident #001's transfers.

Resident #001's care plan indicated that the resident required two person assistance for transferring and toileting using a mechanical lift.

The home's investigation notes documented that the day prior to resident #001's transfer to hospital, PSWs #115 and #135 toileted resident #001 with a mechanical lift. The PSWs left the resident seated on the toilet on their own and returned few minutes later.

PSW #115 told the inspector that resident #001 was transferred with a mechanical lift. They transferred the resident twice using an identified sling "Y". When the resident was toileted, they and PSW #135 left the resident alone seated on the toilet with the sling attached to the mechanical lift so they could attend to other residents. PSW #115 indicated the sling was not detached from the mechanical lift as the resident was not able to sit on the toilet without support. The PSW told the inspector that this had been a practice in the home and had been leaving residents on their own when toileted, with the sling attached to the mechanical lift.

PSWs #118, #119, #126 and #104 indicated they used an identified sling "X", and PSWs #128 and #115 used the identified sling "Y" for resident #001's transfers, instead of the assessed sling "Z" as per the plan of care.

DOC #100 confirmed that staff did not use the assessed sling "Z" for resident #001's transfers, the sling size should have been included in the resident's care plan, resident #001 was not to be left alone while seated on the toilet for safety, and it was best practice and the home's policy that staff detach the sling from the mechanical lift when resident #001 was seated on the toilet. The DOC acknowledged that staff did not use safe transferring devices and techniques when assisting resident #001.

Sources: Review of resident #001's clinical records, CIS #2985-000005-21 and interviews with DOC #100, PSWs #115, #118, #119, #126, #104 and other staff. (665)

2. As a result of non-compliance identified for resident #001, the sample was expanded to residents #007 and #005.

Resident #007 was a new admission to the home on an identified date.

The home's policy titled, Resident Safe Handling-Minimal Lift Policy, directed staff to assess each resident for the most appropriate lift/transfer method within 24 hours of admission. The assessment information and intervention(s) were to be documented in the resident's care plan and progress notes. The appropriate size sling was based on the size of the resident when mechanical lifts were used. Another policy titled, Slings-Use of and Sanitization, directed staff to assess size and type of sling to be used on each resident by measuring the resident using a sling measuring tape and determining the purpose of the sling (transfer or hygiene). The policy provided instructions on using the sizing guide tape for slings. The home also used another Size Guide to assess the appropriate size sling for residents based on weight.

Review of the resident's Admission Assessment and Care Plan, showed the resident's transfer status including the assessed sling size and type was not documented. A progress note on admission day, documented the resident was transferred with a mechanical lift, but did not include the assessed sling size and type.

RPN #132 and RN #116 indicated that the physiotherapist (PT) conducted the transfer assessment for new residents in collaboration with the registered staff. Both stated that the PSWs assessed the type and size of sling to be used for mechanical lift transfers. The staff were not aware of the home's Size Guide for slings and the sizing guide tape. RPN #132 and RN #116 acknowledged that resident #007's transfer assessment had not been completed as per the home's policy.

PT #117 indicated that they conduct an initial assessment which included a transfer assessment in collaboration with the direct care staff within seven days of any new admission. The nursing staff were responsible for ongoing transfer and sling assessments and would get involved in the re-assessment when requested by the nursing staff.

During observations conducted on two consecutive days, PSWs #119, #126 and #104 used an identified sling "X", to transfer the resident onto the toilet with a mechanical lift. The following day, it was observed that the sling was attached to the mechanical lift while the resident was seated on the toilet.

DOC #100 indicated that for new resident admissions, staff reviews clinical records from Home and Community Care Support Services (HCCSS) as part of the residents' transfer assessment. The HCCSS' clinical records had documentation of resident #007's weight. The DOC verified that based on the resident's weight and the Size Guide for slings, staff were to have used an identified sling "Y" instead of sling "X" for resident #007's transfers. The DOC indicated that staff should have detached the sling from the mechanical lift when resident #007 was seated on the toilet, as it was best practice and the home's policy. The DOC acknowledged that the home did not use safe transferring devices and techniques when assisting resident #007.

Sources: Observations on two identified dates; record review of Resident Safe Handling-Minimal Lift Policy, V2, revised date of July 2021; Slings - Use of and Sanitization Policy, V2, revised date of August 2021, Size Guide for slings, resident #007's clinical records and interviews with DOC #100, RN #116, RPN #132, PSW #119, and other staff. (665)

3. Review of resident #005's care plan, indicated that the resident was transferred with a mechanical lift using an identified sling "X".

Observations conducted on two consecutive days, revealed that PSWs #120 with #118 and #126 with #127 transferred resident #005 from their wheelchair to bed with a mechanical lift and used sling "X". The top of the sling extended approximately one foot past the resident's head in both observations. On the second day of observation, Inspector #665 observed another identified sling "Y" hanging on the resident's door. PSW #126 informed the inspector that they were not aware that sling "Y" was in the room and that both the "X" and "Y" slings were used for resident #005's transfers.

PSW #126 indicated that the registered staff were responsible for the sling assessments which included measuring the residents for the appropriate sling

size, and was documented in the care plan. The PSW was not aware of the home's Size Guide for slings and the sizing guide tape.

RPN #132 and RN #116 indicated that PSWs assessed the type and size of sling to be used for mechanical lift transfers. They were not aware of the home's Size Guide for slings and the sizing guide tape.

Review of resident #005's weights documented their current weight at the time of the inspection. According to the home's Size Guide, an identified sling "Z" was to have been used for the resident.

DOC #100 indicated that it was the responsibility of the PSWs to conduct the sling assessment and that the sizing guide tape was available in the resident home areas for both PSWs and registered staff to measure residents for the sling assessment. The DOC reviewed resident #005's weight and the Size Guide, and acknowledged that staff should have used sling "Z" for transfers. They also informed the inspector that sling "X" used during the inspector's observations, was too big for the resident as the sling should not have extended past the resident's head. The DOC acknowledged that staff did not use safe transferring devices and techniques when assisting resident #005.

Sources: Observations on two identified dates, review of resident #005's clinical records, review of Slings - Use of and Sanitization Policy, V2, revised date of August 2021, Size Guide for slings and interviews with DOC #100, RN #116, RPN #132, PSWs #126, 118, #127 and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to residents #001, #005 and #007 when they were transferred with a mechanical lift by staff. Staff did not use the assessed sling for resident #001 and was left alone attached to the mechanical lift when toileted, the sling used in resident #005's transfer was the incorrect size and resident #007 did not receive a transfer and sling assessment 24 hours after admission and was left attached to the mechanical lift when toileted.

Scope: The scope was widespread because for all three residents reviewed,

staff did not use safe transferring devices and techniques when assisting the residents.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s.36 of O. Reg. 79/10 and one Compliance Order (CO) was issued to the home.

(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 08, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

Service Area Office /
Bureau régional de services : Toronto Service Area Office