Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017;	2017_630589_0011 (A1)	011059-17	Resident Quality Inspection

Licensee/Titulaire de permis

BETHANY LODGE FOUNDATION
23 Second Street MARKHAM ON L3R 2C2

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

BETHANY LODGE
23 Second Street MARKHAM ON L3R 2C2

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

JOANNE ZAHUR (589) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Order served under O.Reg. 79/10, r. 36 had a compliance date of October 27, 2017. The Licensee requested an extension to the compliance date to November 3, 2017, to ensure all components of order were met. The extension to the compliance date was approved to now reflect November 3, 2017

Issued on this 23 day of October 2017 (A1)

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

Original report signed by the inspector.

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JOANNE ZAHUR (589) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27 & 28, 2017.

The following two critical incident intakes were inspected concurrently with the resident quality inspection:

-#003419-17 related to responsive behaviour, and

-#008001-17 related to transferring and positioning technique.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping aide (HA), Maintenance worker (MW), Environmental Services Manager (ESM), Dietary Aide (DA), Quality Assurance Nurse (QAN), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) co-ordinator, Registered Dietitian (RD), Food Services Manager (FSM), Physiotherapist (PT), and Education co-ordinator (EC).

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service and medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
7 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	Legendé 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 staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to an incident that had occurred involving

resident #001. The CIS further revealed that resident #001 sustained an injury that resulted in a transfer to hospital.

Review of resident #001’s documentation notes revealed staff #135 and staff #142 had provided personal care to resident #001. Upon returning to resident #001’s room, staff #127 was present to assist staff #135 with the transfer so staff #142 left the room. Shortly after leaving resident #001’s room, staff #142 heard his/her name being called and being told resident #001 had experienced an incident.

Review of resident #001’s most recent written plan of care revealed that he/she required assistance with transfers and that an identified mechanical device was not to be with resident #001 as he/she was not always compliant with following instructions. The written plan of care did not identify the type of transferring equipment required. The written plan of care also revealed resident #001 had limitations related to underlying health conditions.

In interviews, staff #127 and #135 stated that during the transfer, resident #001s sudden movement resulted in an incident. Staff #135 further stated he/she had previously used this transferring device for resident #001 without any incident and therefore used it again. PSW #135 also stated he/she had used this transferring devices with resident #001 as it was easy to use and remove.

Review of the manufacturer's instructions revealed this transferring device was to be used with residents that had good upper body strength and head control plus sitting ability, as well the resident’s arms are to be positioned outside the transfer apparatus at all times when in use. The guide further revealed that this transfer device was designed for use with the manufacturer's specific transfer equipment allowing caregivers to remove resident clothing with ease as are constructed using less material.

In an interview, staff #139 stated that related to resident #001s limitations identified above and that he/she was identified as not being compliant with following instructions, the use of the above mentioned transfer device was an unsafe transferring technique.

In an interview, staff #101 stated resident #001s condition had deteriorated and was no longer able to follow instructions and therefore now required alternate transfer devices for all transfers.

In an interview, staff#130 stated the transfer device used would have been acceptable if was being used for the purpose that it was designed.

In an interview, staff #144 acknowledged the home had failed to ensure staff use safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

2. A CIS was submitted to the MOHLTC related to an incident involving resident #001. The CIS further revealed that resident #001 had sustained an injury related to this incident.

Resident #001 no longer resides in the home and due to non-compliance with O. Reg., 79/10 under r. 36 with resident #001, the scope of this inspection was increased to include resident #004.

Observations by inspector #507 revealed that staff #110 and #111 used an identified transfer device to transfer resident #004 between two surfaces. During the transfer inspector #507 further observed that when the transfer was in progress resident #004 experienced involuntary body movement and staff #111 asked resident #001 to relax. The transfer was completed and the transfer device was removed.

Review of resident #004's most recent written plan of care revealed that he/she required to be transferred using transfer devices. The written plan of care did not indicate the type of transfer devices required.The written plan of care further revealed that resident #004 had limitations and was required to wear an assistive aid to provide support and comfort. The range of motion (ROM) focus revealed that resident #004 had further limitations to identified body parts and required assistance with balance.

In an interview, staff #139 stated based on the above mentioned assessments, the use of the identified transfer device was an unsafe transferring technique.

In an interview, staff #144 acknowledged staff #110 and #111 had not used safe transferring technique when assisting resident #004.

The severity is actual harm to resident #001 and potential of harm to resident #004, and the scope is a pattern, as two of three resident observed revealed unsafe

transfer techniques with the transfer apparatus. Compliance history revealed previous non-compliances unrelated to O. Reg. 79/10, r. 36. As a result of actual harm to resident #001 a compliance order is warranted. [s. 36.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

As a result of observations during the completion of the mandatory medication inspection protocol, an inspector initiated inspection was conducted related to O. Reg. 79/10, s. 3., related to medication management.

Observations during a medication administration pass, revealed staff #118 discarding medication pouches containing personal health information in a garbage bag attached to the medication cart.

In an interview, staff #118 stated once the medication has been administered to the resident the medication pouch is discarded in the garbage bag attached to the cart. Staff #118 further stated the housekeeper disposes of the garbage bag during the shift.

In an interview, staff #103 stated the garbage bag containing empty medication pouches is removed and discarded with the general garbage down the garbage chute.

In an interview, staff #144 indicated the used medication pouches containing personal health information are to be disposed of in the sharps container, or placed in the medication room's sink in water to remove the personal health information prior to discarding in the garbage. [s. 3. (1) 11. iv.]

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 resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

A CIS was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to an incident that had occurred involving resident #001. The CIS further revealed that resident #001 sustained an injury.

Review of resident #001's most recent written plan of care revealed that resident #001 required assistance with transfers when using transfer devices. The written

plan of care did not identify the type transfer devices required.

In an interview, staff #135 stated an identified transfer device was used to transfer resident #001 on the day of the incident. Staff #135 further stated he/she had always used this transfer device for resident #001 so just had continued to use it for transfers.

In an interview, staff #142 stated that the written plan of care should have indicated to staff the type of transfer devices required for transfers. Staff #142 further stated he/she had assumed that since staff #139 had assessed resident #001's mobility and transfer requirements that he/she had updated the written plan indicating to staff the transfer equipment requirements of resident #001.

In an interview, staff #144 acknowledged that by not identifying resident #001's transfer equipment requirements, the home had failed to set out clear direction to staff who provide direct care to the resident. [s. 6. (1) (c)]

2. A CIS was submitted to the MOHLTC related to an incident involving resident #001. The CIS further revealed that resident #001 had an incident in which he/she sustained an injury.

Resident #001 no longer resides in the home and due to non-compliance with O. Reg., 79/10 s. 6., the scope of this inspection was increased to include resident #004.

Observations by inspector #507 revealed that staff #110 and #111 used an identified transfer device with resident #004. Inspector #507 further observed that during the transfer resident #004 experienced involuntary body movement and staff #111 asked resident #001 to relax. The transfer was completed and the transfer device was removed.

Review of resident #004's most recent written plan of care revealed that he/she required to be transferred with a transfer device. The written plan of care did not indicate the type of transfer devices required.The written plan of care further revealed that resident #004 had limitations and was required to wear an assistive aid to an identified body part to provide support and comfort. The functional ROM focus revealed that resident #004 had further limitations to identified body parts which required assistance with balance.

In an interview, staff #110 stated resident #004 does not have his/her own transfer device and that after many years of experience you know what size and type of transfer equipment devices a resident requires.

In an interview, staff #144 acknowledged that staff #110's above response was not acceptable and since the written plan of care did not identify resident #004's transfer equipment requirements, the home had failed to set out clear direction to staff who provide direct care to the resident. [s. 6. (1) (c)]

3. During stage two of the RQI, inspector #153 observed a posted memo from staff #105, on an identified nursing station indicating two resident rooms had locking systems installed that required a key to access their rooms.

As a result of observations during stage one of the RQI of door locking systems on two identified resident rooms, an inspector initiated inspection related to dignity, choice and privacy was conducted.

In an interview, staff #153 raised concerns related to two residents in the home that had locking systems to the main entrance door of their rooms, and a secondary locking system on the door between the residents' room and the shared washroom. Staff #153 also stated that the key to access the resident's room was located outside the residents' room under a four sided, display box that had an open base.

Observations by the inspector revealed a locking system in place on the door to an identified resident room door and with the lock engaged. The inspector observed a key attached to a retractable cord that was located under the four sided wooden box located outside the resident #021's room. An attempt to gain entry into resident #021's room through a shared washroom was unsuccessful, as the door was secured from inside resident #021's room.

Review of resident #021's most recent written plan of care failed to reveal that a locking system was in place.

In an interview, staff #120 stated that changes in residents' care needs are communicated during the shift change report and in the plan of care. Staff #120 further stated that information related to the locking system on the resident #021's door and the location of a key to gain entry to the room was documented in the resident's plan of care; however, following a review of the plan of care he/she was

unsuccessful in locating the requested information.

In an interview, staff #145 stated that in addition to entering resident #021's room through the main entrance door, staff are also able to access the resident's room through the shared washroom.

In interviews, staff #116 and #152 indicated the washroom door is locked whether, or not resident #021 is in his/her room.

In an interview, staff #130 revealed he/she was aware there were two residents in the home that had locking systems in place.

In an interview, staff #144 stated he/she was not aware there were locking systems on resident washroom doors. Staff #144 also stated that registered staff are responsible to update the plan of care when resident care needs change, and to communicate these changes to the direct care staff. Staff #144 indicated the home's expectation is that the installation of the locking system on resident #021's door should have been recorded in the resident's plan of care. [s. 6. (1) (c)]

4. During stage two of the RQI, inspector #153 observed a posted memo from staff #105, on the second floor nursing station indicating two resident rooms, had locking systems installed that required a key to access the rooms.

As a result of observations during stage one of the RQI of door locking systems to two identified resident rooms, an inspector initiated inspection related to dignity, choice and privacy was conducted.

In an interview, staff #153 raised concerns related to two residents in the home that had keyed locks on the main entrance door to their rooms, and a hook-type lock on the door between the residents' room and the shared washroom. The staff member also stated that the key to access the resident's room was located outside the residents' room under a four sided, display box that had an open base.

Observations by the inspector revealed the main entrance door to an identified resident room was slightly ajar and a keyed lock system was in place on the door. On entering the room, an alternate locking system was also observed attached to a door that lead to the shared washroom inside resident #020's room. The inspector observed a key attached to a retractable cord that was located under a four sided wooden box located outside resident #020's room. The inspector locked the main

entrance to this identified room and then used the key to reopen the door. Further observations did not reveal a copy of the memo previously observed on the above mentioned nursing station.

Review of resident #020's most recent written plan of care failed to reveal communication related to locking systems.

In an interview, staff #114 stated that resident #020 had a locking system to his/her room and this had been removed two months earlier. Staff #114 also stated that resident #020 had a key though, not a lot of people knew about it. When asked whether the plan of care was updated after the locking system was installed, staff #114 stated that he/she did not believe it had been updated.

In an interview, staff #120 stated resident #020's plan of care included information about locks on the resident's room door; however, after reviewing the plan of care, he/she was unable to locate this information.

In an interview, staff #130 revealed he/she was aware of two residents with locking systems on their room doors but was unable to recall the room numbers.

In an interview, staff #105 stated there was only one resident in the home with an alternate locking system on the washroom door and this room was located on the second floor. Staff #105 was unaware of an alternate locking system that was installed in this identified room.

In an interview, staff #144 stated that he/she was not aware there were locks on resident washroom doors. Staff #144 further stated that registered staff are responsible for updating the plan of care when residents care needs change; and for communicating these changes to the direct care staff. Staff #144 indicated the plan of care for resident #020 should have included information related to locking systems installed on the resident's doors. [s. 6. (1) (c)]

5. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care.

As a result of dining observations conducted during stage one of the RQI an inspector initiated inspection under O. Reg. 79/10, s. 6. (7) related to Nutrition and Hydration was conducted.

Observations by the inspector at a lunch meal revealed resident #019 eating an alternate diet that was served on an assistive aid. Review of the diet list indicated resident #019's was prescribed a specified diet and fluid consistency. Documentation of the assistive aid was not noted on the diet list.

Further observations at another lunch meal revealed resident #019 was served an alternate diet on an assistive aid. Further review of the diet list continued to indicate resident #019's was prescribed a specified diet and also now included a hand written entry indicating the resident's meal was to be served on an alternate assistive aid.

In an interview, staff #108 stated that resident #019 was prescribed an alternate textured diet to be served on an assistive aid.

In an interview, staff #108 stated that although the resident #019 had a prescribed diet, staff #137 had directed staff to serve resident #019 an alternate therapeutic diet at their discretion. Staff #108 further stated the required assistive aid was not available so an alternate assistive aid was used.

In an interview, staff #137 stated that resident #019 was to receive a specified diet. Staff #137 further stated that the meal resident #019 received was not considered to meet the requirements of an alternate diet. Staff #137 stated resident #019 had been assessed to require an identified diet and should not be served the alternate diet.

In an interview, staff #138 stated that resident #019 was to receive an identified diet on an assistive aid. Staff #138 was unable to locate the required assistive aid in the storage room and indicated it would be ordered from the supplier.

The inspector shared observations relative to the diet served to resident #019 on two identified dates and staff #138 acknowledged that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

6. The licensee has failed to ensure that the provision of the care set out in the plan of care are documented.

During stage one of the Resident Quality Inspection (RQI), resident #006 was triggered for inspection.

Review of the home's PSW Flow Sheets on Point of Care policy, policy #:RCS-1-NURS-DOC-270, revised May 12, 2014, indicated:
-each resident's Point of Care (POC) flow sheet must be completed by the PSW assigned to the care of the resident.
-the PSW to complete the documentation on flow sheets, including Timed Flow Sheets.

During the course of the inspection, the inspector observed resident #006 had a restraint in place while sitting.

Review of resident #006's most recent resident-assessment-instrument mini data set (RAI-MDS) assessment revealed that the resident used an identified restraint daily. Review of resident #006's most recent care plan revealed that the resident uses a restraint for his/her safety, and the monitoring for safety while in restraint is to be reviewed every hour.

In interviews, staff #125 and #134, and staff #129 stated that resident #006 required a restraint to maintain his/her safety. Staff #125 and #134 told the inspector that resident #006 usually sits in his/her chair with a restraint in place from morning meal to after midday meal, and may be put back to bed after midday meal if he/she is tired. Staff #125 and #134 further stated that the assigned PSWs are to check residents having physical restraint hourly for safety and document in the Timed Flow Sheets in the POC accordingly.

Review of the Timed Flow Sheet under the category of Documentation Items and Codes in regards to Restraints revealed that for a total of 20 days over three identified months, hourly monitoring had not been documented for the entire day shift (0600 hours to 1400 hours):

In an interview, staff #144 stated that it is the home's expectation for PSWs to complete all required documentation in the POC before their shift ends. Staff #144 confirmed that hourly monitoring of resident #006's safety while using a restraint was not documented as required. [s. 6. (9) 1.]

7. During stage one of the Resident Quality Inspection (RQI), resident #004 was triggered.

Review of the home's PSW Flow Sheets on Point of Care policy, policy #:RCS-1-NURS-DOC-270, revised May 12, 2014, indicated:

-each resident's Point of Care (POC) flow sheet must be completed by the PSW assigned to the care of the resident.
-the PSW to complete the documentation on flow sheets, including Timed Flow Sheets.

During the course of the inspection, the inspector observed resident #004 had a restraint in place while sitting.

Review of resident #004's most recent RAI-MDS assessment revealed that the resident used a restraint daily. Review of resident #004's most recent care plan revealed that the resident uses a restraint for positioning. The care plan also included hourly check for the resident's safety while the restraint was in use.

In interviews, staff #110 and #141, and staff #130 stated that resident #004 required a restraint to maintain his/her position while in a chair. Staff #110 and #141 told the inspector that resident #004 usually sits in his/her chair with a restraint from morning meal to after after midday meal and may be put back to bed after midday meal if he/she is tired. Staff #110 and #141 further stated that the assigned PSWs are to check residents having physical restraint hourly for safety and document in the Timed Flow Sheets in the POC accordingly.

Review of the Timed Flow Sheet under the category of Documentation Items and Codes in regards to Restraints revealed that for a total of 18 days over three identified months, hourly monitoring had not been documented for the entire day shift (0600 hours to 1400 hours).

In an interview, staff #144 stated that it is the home's expectation for PSWs to complete all required documentation in the POC before their shift ends. Staff #144 confirmed that monitoring of resident #004's safety while wearing a restraint was not documented as required. [s. 6. (9) 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 the plan of care set out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the provision of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

Findings/Faits saillants :

1. The licensee has failed to ensure that any lock on resident's washrooms must be designed and maintained so they can be readily released from the outside in an emergency.

Related to observations during stage one of the RQI of keyed locks on two identified resident doors, an inspector initiated inspection related to Safe and Secure Home was conducted.

Observations by the inspector of washrooms in two identified rooms revealed a locking system affixed to the washroom door preventing access from the shared washroom into the resident's room.

In interviews, resident's #020 and #021 indicated the locks were in place to maintain privacy and prevent wandering residents from accessing their rooms.

In interviews, staff #145, staff #105, and staff #144 indicated they were not aware

of the locking system located on the washroom door on an identified resident room.

In an interview, staff #151 indicated there was no way of releasing the locking system on the washroom doors in two identified rooms therefore, he/she had consulted with a lock smith who would be removing the locks. [s. 9. (1) 3.]

2. Related to observations during stage one of the RQI of keyed locks on two identified resident doors, an inspector initiated inspection related to Safe and Secure Home was conducted.

Observations by the inspector revealed a memo posted identifying two resident rooms were to have locking systems installed that would require keys to unlock. The locks would be keyed to the building's master key system so that doors could be unlocked using the master key. There would also be a key on a retractable key holder attached to the memory boxes located in the hallways just outside the identified rooms for easy access. There was no mention of the alternate locking system that was observed on the washroom doors.

In an interview, staff #153 reported a concern related to residents' safety related to two resident rooms that had locking systems on the entrance to their rooms and an alternate locking system on the shared washroom doors.

Observations by the inspector revealed the shared washroom door to an identified room was noted to be open and inspectors were able to gain access to resident #020's room; however, a door from resident #021's to the shared washroom was noted to be locked, and thereby preventing access to resident #021's room. On further observation, a key with a retractable cord was observed at the opened base of the four sided wooden box that was located just outside the resident's room.

A review of the most recent written plans of care for residents' #020 and #021 failed to reveal communication related to locking systems.

Observations by the inspector revealed that resident #021's room door was locked when the handle was checked. Inspectors attempted to enter the resident's room through a shared washroom and observed that the door was also locked from the other side of the door and the inspectors therefore were unable to gain access. Further observations revealed that an alternate locking system was engaged locking the door.

In interviews, residents #021 and #020 indicated the locking systems were in place to maintain privacy and prevent wandering residents from accessing their rooms.

In an interview, staff #105 stated that information about locking systems on residents' doors was communicated through an email that was sent to registered staff; and was verbally communicated to staff on duty at the time when the main entrance locks were installed. However, staff #105 was not aware how this communication would be extended to staff who worked infrequently, or was contracted from a staffing agency. Staff #105 further stated there was only one alternate locking system in place in the home. At the request of the inspector, staff #105 was unable to provide a policy related to the use of locking systems on resident's doors however, he/she did provide the home's policy titled: Resident Room Door Locks, policy number # ADM-1-GEN-220. The procedure section indicated the administrator and DOC must approve installing the locking system. After receiving approval, the environmental department will arrange to install the door lock. The Health and Safety Committee is notified that a lock will be installed and all staff on the unit will be informed and trained. A review of the policy provided failed to address the installation of locks on resident washroom doors.

In an interview, staff #144 stated he/she was not aware there were locking systems in place on identified residents' washroom doors that could not be readily released.

In an interview, staff #151 acknowledged there were concerns related to staff training and resident safety, as alternate locking systems affixed to resident washroom doors could not be released externally. Staff #151 stated that the locking systems on resident rooms would be removed temporarily to permit the home to address these issues before re-installing the locks.
[s. 9. (1) 3.]

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 any lock on resident's washrooms must be designed and maintained so they can be readily released from the outside in an emergency, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. 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. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

A CIS was submitted to the MOHLTC related to an incident involving resident #001. The CIS further revealed that resident #001 had an incident from a transfer device that resulted in an injury.

1.Review of resident #001's most recent written plan of care revealed that he/she required assistance with a transferring device. The transferring focus also revealed that an identified transfer device was not to be used to transfer resident #001 as he/she was not always compliant with following instructions. The written plan of care did not identify the type of transferring devices required. The written plan of care revealed resident had limitations related to underlying health conditions.

In interviews, staff #127 and #135 stated they had used an identified transferring device to transfer resident #001. During the transfer resident #001 sudden movement resulted in resident #001 sustaining an injury from an incident. Staff #135 further stated he/she had previously used the above mentioned transfer device for resident #001 without any issues and therefore had used it on the day of the incident. Staff #135 also stated the identified transfer device had been used with resident #001 as was easy to use and remove.

Review of the manufacturer's instructions revealed this transferring device was to

be used with residents that had good upper body strength and head control plus sitting ability, as well the resident’s arms are to be positioned outside the transfer apparatus at all times when in use. The guide further revealed that this transfer device was designed for use with the manufacturer's specific transfer equipment allowing caregivers to remove resident clothing with ease as are constructed using less material.

In an interview, staff #139 stated related to limitations identified above and that resident #001 was identified as not being compliant with following instructions, the use of the identified transfer device for transfers was inappropriate.

In an interview, staff#130 stated the transfer device used would have been acceptable if was being used for the purpose that it was designed.

In an interview, staff #144 acknowledged the home had failed to ensure staff had used transfer devices in accordance with manufacturers' instructions.

2. A CIS was submitted to the MOHLTC related to an incident involving resident #001. The CIS further revealed that resident #001 had an incident from a transfer device resulting in an injury.

Resident #001 no longer resides in the home and due to non-compliance with O. Reg., 79/10 under r. 36 with resident #001, the scope of this inspection was increased to include resident's #004.

Observations by inspector #507 revealed that staff #110 and #111 used an identified transfer device to transfer resident #004 between two surfaces. During the transfer inspector #507 further observed that when the transfer was in progress resident #004 experienced involuntary body movement and staff #111 asked resident #001 to relax. The transfer was completed and the transfer device was removed.

Review of resident #004's most recent written plan of care revealed that he/she required to be transferred using transfer devices. The written plan of care did not indicate the type of transfer devices required.The written plan of care further revealed that resident #004 had limitations and was required to wear an assistive aid to provide support and comfort. The functional ROM focus revealed that resident #004 had further limitations to identified body parts and required assistance with balance.

In an interview, staff #139 stated based on the above mentioned assessments related to limitations, the use of the transfer device used was inappropriate.

In an interview, staff #144 acknowledged staff #110 and #111 had failed to use transfer devices in accordance with manufacturers' instructions. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

During stage one of the RQI, resident #003 triggered for skin and wound.

Review of the progress notes of resident #003 revealed that the resident sustained two areas of altered skin integrity.

Record review of the nutrition assessment for resident #003 for an identified time period, failed to reveal an assessment by the registered dietitian had been completed.

In an interview, staff #137 told the inspector that he/she would have assessed resident #003 if had been made aware of the above mentioned altered skin integrity. As result a nutritional assessment was not completed by staff #137 for resident #003 until the inspector inquired about. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI, resident #003 triggered for skin and wound.

Review of resident #003's progress notes revealed that the resident sustained two areas of altered skin integrity.

Record review of assessments related to resident #003 altered skin integrity revealed they had not been completed for an identified date.

In an interview, staff #120 told the inspector that he/she had not assessed resident #003, as he/she was not aware of the altered skin integrity. After a review of resident #003's incident notes, staff #120 stated that an assessment had not been completed for an identified date.

In an interview, staff #144 acknowledged that weekly assessments of altered skin integrity should have been completed by registered staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to him/herself unless the administration has been approved by the prescriber in consultation with the resident.

An inspector initiated inspection was conducted in response to observations conducted during stage one of the RQI.

During stage one of the RQI, observations by the inspector revealed medications left on a table in resident #015's washroom.

In an interview, resident #015 stated staff had removed the medication from the resident's washroom for safekeeping. Resident #015 further stated that he/she is accustomed to self-administering and found it an inconvenience waiting for the nurse to bring it to him/her.

Review of the physician's orders indicated that resident #015 had been prescribed a medication and a subsequent order to discontinue this medication was also noted. There was no physician order located on the health record to authorize resident #015 could self-medicate.

In an interview, staff #118 stated there were no residents that were self-

administering medications in the home area. Staff #118 also stated the home's practice is to remove discontinued medications and place them in a separate bin in the medication room for disposal upon receipt of a physician order to do so.

Review of the home's policy titled: Self Administration of Medication, policy #:RCS-1-NURS-Resident Care-200, indicated the home will ensure that no resident administers a drug to him/herself unless this has been approved by the prescriber in consultation with the resident.

In an interview, staff #144 stated the home's policy requires an assessment of the resident's ability to self-administer medications and to ensure that medications are safely stored in a locked, steel box in the resident's room. Staff #144 further stated that at this time there was no resident in the home who was self-medicating.

As a result of this review, the licensee has failed to ensure that resident #015 self-administered medications only when they are approved by the prescriber in consultation with the resident. [s. 131. (5)]

2. The licensee has failed to ensure that no resident who is permitted to administer a drug to him or herself, keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

During stage one of the RQI observations by the inspector revealed two medications on a table in resident #015's washroom.

In an interview, resident #015 stated staff had removed the medication from the resident's washroom for safekeeping. Resident #015 further stated that he/she is accustomed to self-administering these medications found it an inconvenience waiting for the nurse to bring it to him/her for self-administration.

Review of resident #015's Quarterly Medication Review (QMR) completed by the physician for a identified period indicated the resident was to self-administer an identified medication at a prescribed time.

Review of the physician's orders indicated that resident #015 had been prescribed a medication and a subsequent order to discontinue this medication was also noted. There was no physician order located on the health record to authorize resident #015 could self-medicate.

Review of the Home's policy titled: Self Administration of Medication, policy #:RCS-1-NURS-Resident Care-200 indicated the home will ensure that, all drugs must be kept in a safe place - Bethany Lodge will provide a lock box in the resident's room.

Further review of resident #015's medical records failed to reveal an assessment had been completed to determine resident #015's ability to self-administer medications. A locked steel box was not observed in the resident's room.

In an interview, staff #118 stated there were no residents self-administering medications on an identified home area. Staff #118 further stated the home's practice was to remove discontinued medications and place them in a separate bin in the medication room for disposal upon receipt of a physician order to do so.

In an interview, staff #144 stated the home's expectation is for staff to discard medications when they are discontinued. He/she further stated the home's policy is for residents with a desire to self-administer medications are assessed to determine the ability to do so and ensuring that medications are safely stored in a locked, steel box in the resident's room. Staff #144 also stated that currently, there are no residents in home that is self-medicating.

As a result of this review, the licensee has failed to ensure that no resident who is permitted to administer a drug to him or herself, keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident. [s. 131. (7)]

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 no resident administers a drug to herself unless the administration has been approved by the prescriber in consultation with the resident, and ensure that no resident who is permitted to administer a drug to him or herself, keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #8: 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 participate in the implementation of the infection prevention and control program.

1.Observations by the inspector on the third floor dining room revealed staff #100 remove soiled plates and cutlery from the dining room table, scrape the food into a receptacle located on a cart near the entry to the dining room and then proceed to serve resident #016 an entrée and assist residents' #017 and #018 with feeding without performing hand hygiene.

In an interview, staff #100 stated that he/she had forgotten to do hand hygiene after disposing of soiled plates and utensils. He/she further stated the home's expectation is to perform hand hygiene after disposing of soiled plates and utensils to avoid cross contamination between residents.

In an interview, staff #101 stated the home's expectation is for staff to perform hand hygiene after removing soiled plates and utensils and between residents' care to avoid spreading infection. Staff #101 acknowledged staff #100 had not followed the home's infection control practice related to hand hygiene.

In an interview, staff #144 acknowledged that staff #100 should have washed his/her hands.

2. Observations during the initial tour of the home revealed the following unlabeled items in an identified spa room:
•five combs with dark residue
•one unclean hair brush
•two bottles of cream for heel dryness
•0ne bottle body cream,
•spray deodorant.

In an interview, staff #102 stated the home's expectation is for residents' personal items to be labeled when being stored in common care areas and acknowledged that the above listed items were not labeled. Staff #102 also stated the cream used for heel dryness, body cream and spray deodorant was for communal use.

In an interview, staff #144 stated that it was unacceptable to have unlabeled personal care items in the shower/spa rooms; and all items should be labeled to prevent cross contamination and infection.

3. Observations conducted during a medication administration pass revealed staff #118 administering medications to residents in two identified rooms without completing hand hygiene between these activities. Staff #118 was also observed to administer insulin, then administer eye drops, then oral medications without completing hand hygiene during these activities.

In an interview, staff #118 stated it was the home's expectation to complete hand hygiene between resident care and believed he/she had complied with the expectation.

In an interview, staff #144 stated the home's expectation was for staff to complete hand hygiene during any invasive procedures, which included administering eye drops.

In the above situations, staff did not participate in the implementation of the infection prevention and control program, as they failed to complete hand hygiene and label residents personal care items that were stored in common care areas. [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 infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During stage one of the RQI an observation of resident #011's washroom revealed an extensive brown stain at the base of the toilet bowl.

During an observation in stage two of the RQI, the toilet in resident #011's washroom was noted to still have a large brown stain at the base of the toilet bowl.

In an interview, resident #011 stated he/she was aware of the stain in the bathroom fixture but had not reported it to staff.

In an interview, #107 stated that a brown stain was observed at the base of the toilet bowl in an identified room two weeks earlier and it had been reported to staff #103 and staff #104 and that there had been minimal improvement of the stain. Staff #107 further stated he/she had also reported the stained toilet bowl to staff #105 and had suggested changing the toilet.

In an interview, staff #103 stated there had been an ongoing problem with corrosion in the toilet bowls for approximately one year; and currently, there are approximately more than 10 toilets with corrosion, of which, the majority have raised toilet seats.

In an interview, staff #106 revealed he/she had observed stains on bathroom fixtures in two identified resident rooms and was unable to remove the stain. He/she stated this had been reported to staff #105.

In an interview, staff #105 denied receiving a maintenance request on an identified date, for a stained toilet in an identified room, and was not aware of the stained toilet bowl. Staff #105 later stated the contracted housekeeping company had conducted an audit of the home noting that all rooms were checked and there was soiling at the base of the toilet bowls. The target date for completion was as soon as possible (ASAP). Staff #105 also stated that conventional cleaners used in the home were ineffective in removing the stain and an outside company was contacted to provide an alternate cleaner.

Staff #105 accompanied the inspector to the above mentioned resident room where the stain was observed at the base of the toilet bowl. Staff #105 stated that the home was in the process of removing stains in toilet bowls throughout the home. [s. 15. (2) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was notified of the outcome or current status of the individual who were involved in the incident.

A CIS was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to fall incident that occurred involving resident #001. The CIS further revealed that resident #001 had an incident sustaining an injury.

Review of CIS revealed the home had amended the CIS on an identified date, indicating resident #001 had not been re-admitted to the long term care home (LTCH) related to other developments and therefore a discharge date had not been set at that time. This amendment further revealed that resident #001 was now stable from the injury. Further review of the CIS revealed on page 3 that the Director had requested the CIS be further amended with date of resident #001's re-admission and status upon return.

Review of resident #001's progress notes revealed that he/she was re-admitted to the home on an identified date in stable condition. Three days later resident #001 required a transfer related to a change in health status.

Review of the Ministry of Health's Long Term Care portal revealed there had not been any further amendments to the CIS after an identified date.

In an interview, staff #143 acknowledged he/she had not seen the request for a further amendment and confirmed that the CIS had not been amended with resident #001's re-admission date and status upon return. [s. 107. (4) 3.]

Issued on this 23 day of October 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE ZAHUR (589) - (A1)

Inspection No. / No de l'inspection : 2017_630589_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 011059-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 23, 2017;(A1)

Licensee / Titulaire de permis : BETHANY LODGE FOUNDATION
23 Second Street, MARKHAM, ON, L3R-2C2

LTC Home / Foyer de SLD : BETHANY LODGE
23 Second Street, MARKHAM, ON, L3R-2C2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Basil Tambakis

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

To BETHANY LODGE FOUNDATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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 shall prepare, submit and implement a plan to ensure that staff use
safe transferring and positioning devices or techniques when assisting residents
with transfers, including but not limited to the following:
1) Ensuring all residents requiring mechanical lifts have the proper lift sling employed,
2) Ensure all staff use the correct lift and sling as assessed for each resident requiring mechanical lift transfers,
3) Provide education to all direct care staff to follow manufacturer specifications for the recommended use of the different types of slings, and
4) Implement an auditing system to ensure staff adherence with safe lifting and
transferring techniques when assisting residents.

Please submit the plan to Joanne.zahur@ontario.ca no later than August 4, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

A CIS was submitted to the MOHLTC related to an incident involving resident #001. The CIS further revealed that resident #001 had sustained an injury related to this incident.

Resident #001 no longer resides in the home and due to non-compliance with O. Reg., 79/10 under r. 36 with resident #001, the scope of this inspection was increased to include resident #004.

Observations by inspector #507 revealed that staff #110 and #111 used an identified transfer device to transfer resident #004 between two surfaces. During the transfer inspector #507 further observed that when the transfer was in progress resident #004 experienced involuntary body movement and staff #111 asked resident #001 to relax. The transfer was completed and the transfer device was removed.

Review of resident #004's most recent written plan of care revealed that he/she required to be transferred using transfer devices. The written plan of care did not indicate the type of transfer devices required.The written plan of care further revealed that resident #004 had limitations and was required to wear an assistive aid to provide support and comfort. The range of motion (ROM) focus revealed that resident #004 had further limitations to identified body parts and required assistance with balance.

In an interview, staff #139 stated based on the above mentioned assessments, the use of the identified transfer device was an unsafe transferring technique.

In an interview, staff #144 acknowledged staff #110 and #111 had not used safe transferring technique when assisting resident #004.

(589)

2. A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to an incident that had occurred involving

resident #001. The CIS further revealed that resident #001 sustained an injury that resulted in a transfer to hospital.

Review of resident #001's documentation notes revealed staff #135 and staff #142 had provided personal care to resident #001. Upon returning to resident #001's room, staff #127 was present to assist staff #135 with the transfer so staff #142 left the room. Shortly after leaving resident #001's room, staff #142 heard his/her name being called and being told resident #001 had experienced an incident.

Review of resident #001's most recent written plan of care revealed that he/she required assistance with transfers and that an identified mechanical device was not to be with resident #001 as he/she was not always compliant with following instructions. The written plan of care did not identify the type of transferring equipment required. The written plan of care also revealed resident #001 had limitations related to underlying health conditions.

In interviews, staff #127 and #135 stated that during the transfer, resident #001s sudden movement resulted in an incident. Staff #135 further stated he/she had previously used this transferring device for resident #001 without any incident and therefore used it again. PSW #135 also stated he/she had used this transferring devices with resident #001 as it was easy to use and remove.

Review of the manufacturer's instructions revealed this transferring device was to be used with residents that had good upper body strength and head control plus sitting ability, as well the resident's arms are to be positioned outside the transfer apparatus at all times when in use. The guide further revealed that this transfer device was designed for use with the manufacturer's specific transfer equipment allowing caregivers to remove resident clothing with ease as are constructed using less material.

In an interview, staff #139 stated that related to resident #001s limitations identified above and that he/she was identified as not being compliant with following instructions, the use of the above mentioned transfer device was an unsafe transferring technique.

In an interview, staff #101 stated resident #001s condition had deteriorated and was no longer able to follow instructions and therefore now required alternate transfer devices for all transfers.

In an interview, staff#130 stated the transfer device used would have been acceptable if was being used for the purpose that it was designed.

In an interview, staff #144 acknowledged the home had failed to ensure staff use safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

(589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Nov 03, 2017(A1)

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 23 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE ZAHUR - (A1)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Service Area Office / Bureau régional de services : Toronto