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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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5700 Yonge Street, 5th Floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2013	2013_162109_0011	T1991-2037-2047-12	Complaint

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street, NORTH YORK, ON, M3J-1M7

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

Downsview Long Term Care Centre
3595 Keele Street, NORTH YORK, ON, M3J-1M7

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): February 7, 8, 2013

Non-compliance evidence for resident's # 9 and 10 were inspected under Inspection #: 2013_162109_0013 Log #: T2120-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Personal Support Workers, resident # 1.

During the course of the inspection, the inspector(s) Reviewed the health record for residents # 1, 2, & 3, observed care activities on the unit

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 plan of care for resident # 2 states that the staff are to use a sit/stand lift with 2 staff for all transfers. Inspector asked the assigned PSW #1 how the resident was lifted out of bed on a specified date. PSW # 1 stated that the ceiling lift was used with the assistance of PSW # 2. PSW # 2 told the Inspector that she/he did not assist PSW # 1 with the transfer. The wrong lift was used on this resident and the resident was transferred by one staff member instead of two. [s. 36.]

2. The plan of care for resident # 3 states to use a "hoyer" lift and 2 staff for all transfers. PSW # 2 stated that she/he did not assist the assigned PSW # 1 with transferring this resident out of bed on a specified date. Inspector asked the assigned PSW who assisted with the transfer. The assigned PSW # 1 stated that a PSW from the night shift helped to transfer the resident using the sit/stand lift. The wrong lift was used to transfer the resident. [s. 36.]

3. The licensee failed to ensure that safe transferring devices and techniques were used when assisting residents
Resident # 1 sustained a serious injury after being transferred in an unsafe manner. The resident's plan of care stated to use a full "hoyer" lift and 2 staff for all transfers. On a specified date PSW # 3 transferred resident # 1 by her/himself using a sit/stand lift rather than a "hoyer" lift. The resident fell resulting in serious injury. The PSW then physically lifted the resident off of the floor onto the wheelchair without the mechanical lift. Further to this, PSW # 3 took the resident back to his/her bedroom and again physically lifted the resident without a mechanical lift and without assistance onto the bed. The PSW did not report this incident to the charge nurse or any other person. The following morning, the resident was found to have swelling and excruciating pain in a specified location when touched. The resident was later diagnosed in the hospital with a fracture. The resident has been bedridden since as a result of this injury. [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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. Resident # 1's plan of care for transfers at the time of the incident on a specified date stated that he/she was to be lifted mechanically with the "hoyer" lift. The resident was totally dependent upon staff and required 2 persons for the transfer; one staff to operate the lift, the other staff to guide and support the resident safely.
The care set out in the plan of care was not provided to resident # 1 as specified in the plan. On a specified date PSW # 3 transferred resident #1 with the incorrect mechanical lift. The resident was transferred with a sit/stand lift instead of the full "hoyer" lift as stated on the plan of care. The resident was subsequently physically lifted without a lifting device 2 more times by PSW # 3. Once from the floor back into the wheelchair, and again from the wheelchair into bed. [s. 6. (7)]

2. The care set out in the plan of care was not provided to resident # 2 as specified in the plan. The plan of care for resident # 2 states that the resident requires a standing lift to be used with 2 staff members. According to the assigned PSW (#1), resident # 2 was transferred on a specified date using the ceiling lift instead of a standing lift.
The assigned PSW (#1) stated that she and another identified PSW (#2) lifted the resident with the ceiling lift. PSW # 2 stated that she/he did not assist with the transfer of resident # 2. [s. 6. (7)]

3. The care set out in the plan of care was not provided to resident # 3 as specified in the plan. The plan of care for resident # 3 states that the resident is lifted mechanically. The resident is fully dependent on staff and requires 2 staff with the full "hoyer" lift for transfer from bed to chair or vice versa.
According to the assigned PSW (#1), Resident # 3 was transferred with the sit/stand lift from the bed into the wheelchair on a specified date. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care for resident # 10 was provided as specified in the plan.
Resident # 9 told Inspector that on a specified date resident # 10, his/her roommate was taken to the bathroom by the staff and left there by him/herself. Resident # 10 then attempted to walk back to the bed and fell to the floor. Resident # 9 stated that his/her call bell was activated and was not responded to by the staff. Resident # 9 then telephoned the nursing station after his/her call bell and shouts for help were not responded to.
The progress note written on the specified date for resident # 10 states that resident # 9 called the nursing station and reported that roommate resident # 10 was on the floor.

The plan of care for resident # 10 on the specified date states that resident # 10 can transfer from w/c to toilet with assistance from one staff. Staff is to stay with the resident throughout out the whole toileting process.

NOTE: above evidence relating to resident's # 9 and 10 was inspected under Inspection #: 2013_162109_0013 corresponding to Log #: T2120-12[s. 6. (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 the care set out for transferring residents is provided to the residents as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of February, 2013

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

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2013_162109_0011
Log No. / Registre no:	T1991-2037-2047-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 21, 2013
Licensee / Titulaire de permis :	Downsview Long Term Care Centre Limited 3595 Keele Street, NORTH YORK, ON, M3J-1M7
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christiana Burns

To Downsview Long Term Care Centre Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére 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

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 ensure that all staff use safe transferring devices and techniques with assisting resident # 1, 2, & 3 with transfers.
The licensee shall prepare, submit and implement a plan of action detailing compliance with safe transferring devices and techniques when assisting residents.

Submit plan to susan.squires@ontario.ca by March 8, 2013

Grounds / Motifs :

1. The licensee failed to provide safe transferring devices and techniques when assisting residents
Resident # 1 sustained a serious injury after being transferred in an unsafe manner. The resident's plan of care stated to use a full "hoyer" lift and 2 staff for all transfers. On a specified date PSW # 3 transferred resident # 1 by her/himself using a sit/stand lift rather than a "hoyer" lift. The resident fell resulting in serious injury. The PSW then physically lifted the resident off of the floor onto the wheelchair without the mechanical lift. Further to this, PSW # 3 took the resident back to his/her bedroom and again physically lifted the resident without a mechanical lift and without assistance onto the bed. The PSW did not report this incident to the charge nurse or any other person. The following morning, the resident was found to have swelling and excruciating pain in a specified location when touched. The resident was later diagnosed in the hospital with a fracture. The resident has been bedridden since as a result of this injury. [s. 36.] (109)

2. The plan of care for resident # 3 states to use a "hoyer" lift and 2 staff for all transfers. PSW # 2 stated that she/he did not assist the assigned PSW # 1 with transferring this resident out of bed on a specified date. Inspector asked the assigned PSW who assisted with the transfer. The assigned PSW # 1 stated that a PSW from the night shift helped to transfer the resident using the sit/stand lift. The wrong lift was used on this resident. (109)

3. The plan of care for resident # 2 states that the staff are to use a sit/stand lift with 2 staff for all transfers. Inspector asked the assigned PSW #1 how the resident was lifted out of bed on a specified date. PSW # 1 stated that the ceiling lift was used with the assistance of PSW # 2. PSW # 2 told the Inspector that she/he did not assist PSW # 1 with the transfer. The wrong lift was used on this resident and the resident was transferred by one staff member instead of two. (109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 22, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

Ministére 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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of February, 2013

Signature of Inspector / Signature de l'inspecteur : 

Name of Inspector / Nom de l'inspecteur : SUSAN SQUIRES

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