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 sous *la Loi de 2007 sur 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 30, 2019	2019_769646_0004	003216-17, 004283-17, 012830-17, 002441-18, 002975-18, 008501-18, 008642-18, 024669-18, 033028-18, 033197-18, 001211-19	Critical Incident System

Licensee/Titulaire de permis

Delcare LTC Inc.
4800 Dufferin Street TORONTO ON M3H 5S9

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

Cawthra Gardens
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

IVY LAM (646), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 21, 22, 25, 26, 27, 28, 2019; April 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, and 15, 2019.

The following Critical Incident intakes were inspected during this inspection:
- Logs #033028-18 and #001211-19 related to Safe Transfer,
- Logs #024669-18, #008642-18, #033197-18, and #033028-18 related to Falls,
- Logs #012830-17, #003216-17, #004283-17, #002441-18, #028380-18 and #002975-18 related to Abuse,
- Logs #002441-18, #002975-18, and #001211-19 related to Responsive Behaviours,
- Log #003216-17 related to Residents' Rights, and
- Log #008501-18 related to Infection Prevention and Control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the home's previous Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Responsive Behaviours Program Lead, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), PSW student, Behavioural Support Ontario (BSO) RPN, BSO-PSW, Registered Dietitian (RD), Corporate Registered Dietitian (CRD), Food Service Manager (FSM), Assistant FSM, Social Worker (SW), Physiotherapist (PT), Residents and Family members.

During the course of the inspection, the inspectors observed resident care, observed staff to resident interaction, observed dining service, reviewed resident health records, reviewed home's record, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

The Ministry of Health and Long Term Care (MOHLTC) received a Critical Incident System (CIS) report regarding an incident that happened during transfer which caused an injury to resident #004 and resulted in a significant change in the resident's health status.

A review of the progress notes on the date of the incident indicated that Personal Support Worker (PSW) #119 assisted the resident for toileting care. The PSW transferred the resident using a different method than what was in the resident's written care plan. As the resident and PSW moved towards the washroom, the resident began to display responsive behaviours toward the PSW. The resident lost their balance in the process and fell on the floor, and was sent to the hospital where they were identified to have sustained an injury.

A review of resident #004's Minimum Data Set (MDS) assessment prior to the incident indicated resident #004 required identified assistance by staff for transferring and toileting care. The MDS record also indicated that the resident was resistive and had identified responsive behaviours toward staff members.

A review of the resident's written care plan prior to the incident identified that the resident was at risk for falls due to identified risk factors, including responsive behaviours. The plan of care indicated the resident required assistance by a specific number of staff for identified activities of daily living. The plan for transfer identified a specific number of staff to provide assistance with transfers. Staff members were to use an identified method to assist resident #004 in getting in and out of the bed, especially at identified times when the resident was tired. The care plan indicated that a specific number of staff members were needed when resident #004 was resistive.

A review of the PSW documentation survey record for three identified months up until the date of the incident indicated that resident #004 was assisted to the toilet by the number of staff specified on the resident's written care plan on all three shifts with the exception of 13 identified shifts. The records showed that the staff who signed off on the shifts was PSW #119.

An interview with PSW #119 indicated that they were aware of resident #004's health condition, needs and interventions. The PSW stated that resident #004 required assistance by a specific number of staff, as the resident was resistive to care with identified responsive behaviours. In an initial interview, PSW #119 stated that on the date of the incident when they went to provide toileting assistance to resident #004, another staff, PSW #121, was present. PSW #119 further stated they got the resident up to sit on the edge of the bed and assisted the resident up. The resident got up and began to be resistive to care and fell to the floor on to an identified side of their body. The PSW was not able to explain how the resident sustained an injury on the opposite side of their body than the side that the PSW said the resident had fallen on, or if the second staff member, PSW #121, saw how the resident fell.

An interview with PSW #121 indicated that at the time of the abovementioned incident, the PSW was providing care for another resident in an identified room which was further down the hall. They heard a "bump" and went to see what happened. The PSW stated they were not in the room where resident #004 resided and had not seen how the resident fell. The PSW also indicated that they were not called to assist resident #004 for toileting, although they were aware that resident #004 needed a specified number of staff members for assistance with bed mobility, transfer, toileting and dressing.

In an interview, Registered Practical Nurse (RPN) #120, indicated that on the day of the incident, they were called by PSW #119 to see resident #004 who was on the floor in their room. The RPN stated that PSW #121 was not in the resident's room on their arrival. Further, the RPN stated that resident #004 had been identified to have responsive behaviours and required assistance by a specified number of staff due to resistiveness with care, and that staff should be aware of the resident's care plan. The RPN further explained the proper transfer techniques and interventions for resident #004 to ensure that the resident was stable prior to ambulating with the resident. If the resident is resistive in the process, the staff was to leave the resident, re-approach them or seek assistance from second staff to provide assistance. The RPN also stated that PSW #119 had told them that during the identified transfer, the resident suddenly demonstrated physical responsive behaviours towards the PSW and the resident lost their balance and

fell. Upon review of the resident #004's written plan of care, the RPN agreed that PSW #119 did not safely transfer the resident.

A review of the home's investigation file of the incident showed that PSW #119's initial statement on the date of the incident was that they were ambulating with resident #004 to the washroom. Before reaching the washroom, the resident suddenly displayed responsive behaviours towards the PSW. The PSW moved back and the resident lost their balance and fell, hitting the floor. PSW #119 called RPN #120 and PSW #121 who was in another resident's room.

A second interview with PSW #119 revealed a discrepancy between the CIS report and the PSW's initial written statement of how they assisted resident #004, and their initial interview with the inspector. In the second interview, PSW #119 indicated that they woke resident #004 up, and after assisting the resident to get up, the resident suddenly pulled away from the PSW, fixed their hair and their clothing and extended their hands again towards the PSW to let the PSW hold them. As they began to walk, the resident suddenly pulled away from the PSW, lost their balance, and fell on an identified side, hitting an identified part of their body on the floor. The PSW stated that the resident did not display responsive behaviours toward the PSW. When PSW #119 was asked about the differences in their statement, they said they forgot how it happened. When they were asked if they had followed the plan of care for safe transferring when assisting resident #004 from bed to the toilet, the PSW did not respond.

In an interview, the Director of Care (DOC) acknowledged that PSW #119 did not follow the direction from the plan of care for safe transferring when they assisted resident #004 to the toilet on the abovementioned date. [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.The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The MOHLTC received a CIS report regarding alleged staff to resident abuse, where a resident sustained identified injuries from the alleged abuse.

A review of the home's investigation record indicated that on an identified date, PSW-student #123 had witnessed that PSW #122 was alone while assisting resident #022 with toileting care, and saw PSW #122 providing rough care to the resident.

A review of resident #022's MDS assessment prior to the incident indicated that the resident had identified cognitive impairment, and exhibited identified responsive behaviours. The resident required a specified number of staff members to provide assistance with identified activities of daily living.

A review of the resident's written plan of care prior to the incident indicated that the resident had been followed by an identified behavioural program with intervention in place. Further, the written care plan identified a specific number of staff members were needed to assist the resident with toileting care due to the resident's responsive behaviours.

A review of the resident's health record indicated that the date the incident was reported, upon assessment, the resident had injuries on two identified areas of the resident's body. The physician had also assessed the resident and confirmed the two identified injuries.

In an interview, PSW #122 confirmed that on the date of the incident, they had provided assistance to resident #022 for identified activities of daily living, and had provided toileting care to the resident twice on their own prior to having the student accompany them the third time that day. The PSW indicated that the resident was resistive, but they were aware of the interventions in the resident's written care plan, and were able to provide the care on their own.

In an interview, the student stated that on the date of the incident, PSW #122 was alone while providing toileting assistance to resident #022. The resident was resistive to care, and the PSW had applied an identified physical force to the resident on an identified part of the resident's body, then proceeded to continue the toileting care for the resident. The student stated that the PSW did not seek assistance from the student or any other PSW to assist with the resident's toileting care.

In an interview, the DOC stated that they expected all staff to follow the directions set in residents' plans of care while providing care to the residents. They acknowledged that PSW #122 did not follow the directions as indicated in the resident #022's plan of care when providing the resident with toileting care. [s. 6. (7)]

2. A CIS report was submitted to the MOHLTC related to an alleged staff to resident physical abuse that occurred on an identified date where resident #013 alleged that staff was rough when giving care to them during an identified shift.

Review of the home's investigation notes and staffing list indicated that PSWs #116 and #136 had provided care for resident #013 on the shift of the alleged incident.

Review of resident #013's diagnosis in the written plan of care at the time of the incident indicated the resident had identified diagnoses and required assistance with bed mobility. The care plan identified a specific number of staff members were needed to reposition resident #013 by an identified method when the resident was in bed. Review of resident #013's identified health records at the time of the incident indicated the resident was at an identified level of cognitive impairment indicated by the Cognitive Performance Scale (CPS) score.

Interview with resident #013's spouse indicated that the resident is not able to provide additional information about the incident, and that the spouse no longer recalled the incident.

Interview with PSW #136 indicated that this was not their usual unit to work on, and while the resident's kardex and care plan were available, they did not look at resident #013's care plan or kardex prior to providing care.

In interviews with PSWs #116 and #136, they mentioned that while providing resident

#013 with care that evening, they had repositioned the resident in an identified manner that was different than what was in resident #013's written plan of care. PSW #136 further indicated that while they were turning the resident, an identified part of the resident's body was caught underneath the resident, and the resident began to have identified responsive behaviours toward PSW #136. PSW #136 stated that it was difficult to understand the resident, and they were unaware of the limitations to resident #013's movements. Interview with the Assistant Director of Care (ADOC) indicated the staff were to reposition the resident in the identified manner as per the resident's written care plan.

Interviews with the ADOC and the DOC acknowledged that the staff were expected to provide resident #013 with the care set out in their care plan, and they did not do so. [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 in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #022 was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the definition of "abuse", O. Reg. 79/10, in subsection 2 (1) of the

Act, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

The MOHLTC received a CIS report regarding alleged abuse by staff to three residents, and one of the three resident was alleged to have been physically abused with identified injuries.

A review of the home's investigation record indicated that on an identified date, PSW-student #123 approached the ADOC and reported that they witnessed PSW #122 being abusive towards residents #009, #021, and #022. The incident had occurred several days prior to the student's reporting of the incident. A record review of the student's written statement indicated that on the date of the incident, they had witnessed that PSW #122 applied an identified physical force on resident #021 on an identified part of the resident's body while the resident was seated in a chair. They also observed PSW #122 behaving in a demeaning manner towards resident #009, and had stated that the PSW was also rough when transferring resident #022 and when providing toileting assistance to the resident. In their note, the student indicated they had gone with the PSW to an identified common area where resident #022 was sitting to bring the resident to the washroom for toileting care. The resident became resistive to care with the PSW, and PSW #122 applied an identified physical force on an identified part of the resident's body in the identified residents' area. In the washroom, the PSW again applied an identified physical force on the resident while continuing to provide the identified care for the resident. The student further stated that while the resident was on the toilet, the PSW applied an identified force on the resident twice on an identified part of the resident's body. The home's investigation notes indicated that resident #009 and resident #021 did not sustain any injury when assessed. However, assessment of resident #022 had identified two injuries on two identified areas of the resident's body.

A review of resident #022's MDS assessment prior to the incident indicated that the resident had identified cognitive impairment and exhibited identified responsive behaviours. The resident needed an identified number of staff to provide assistance with identified activities of daily living.

A review of the resident's written plan of care prior to the incident indicated that the resident had been followed by an identified behavioural program with interventions in place. The written care plan indicated an identified number of staff members were needed to assist the resident with toileting due to the resident's responsive behaviour.

A review of the resident's health record indicated that on the date the incident was reported, the resident had identified injuries on two identified areas of the resident's body upon assessment. The physician also assessed the resident and confirmed the identified injuries.

The home's investigation record indicated that the student had confirmed their allegation of abuse of the identified residents by PSW #122 during the initial interview with the home. However, PSW #122 denied the allegations of abuse towards the abovementioned residents. According to the investigation notes, PSW #122 had been removed immediately from the home and was terminated after the completion of the investigation.

In an interview, the student confirmed what they stated during the home's investigation as indicated above.

In an interview, PSW #122 denied all the allegations that they had been abusive towards the identified residents mentioned above. The PSW also indicated that they had received education about abuse and were well aware of what constituted abuse, but stated that the care they provided to the residents was not abuse.

Interview with the DOC confirmed that all the staff had received education regarding the home's zero tolerance of abuse policy, and all staff members were expected to practice and provide care to the residents while protecting them. The DOC further indicated that they were not involved in the investigation of this particular incident. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

A CIS report was submitted to the MOHLTC related to an alleged staff to resident physical abuse on an identified date where resident #013 alleged that staff was rough when giving care during an identified shift.

Review of the home's investigation notes indicated the resident had exhibited responsive behaviours during care on the identified shift, and PSW #136 had responded to the resident that they would notify identified authorities if the resident continued to exhibit the identified behaviour. Interviews with RN #117 and PSWs #111 and #137 who worked regularly with resident #013 indicated that the resident was pleasant to work with and was not resistive to care.

In an interview with PSW #116, they stated that PSW #136 had responded to resident #013 during care that if the resident continued the identified responsive behaviour, PSW #136 would notify the identified authorities. PSW #116 further stated that PSW #136 should not respond to residents in that way as it was not respectful.

In an interview with PSW #136, they indicated that they had provided care for resident #013 on the identified shift with another PSW. While they were providing the care, an identified part of the resident's body was caught underneath the resident, and the resident began to respond with identified responsive behaviours towards PSW #136. PSW #136 confirmed that they told the resident that they would notify the identified authorities if the resident continued to exhibit the identified behaviour. The PSW further stated that the managers had spoken with the PSW after the incident, and had provided education on residents' rights.

Interviews with the ADOC and the DOC acknowledged that by telling the resident they would notify the identified authorities if the resident continued their behaviour, the staff did not treat the resident with courtesy and did not respect the resident's dignity. [s. 3. (1) 1.]

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

Issued on this 2nd day of May, 2019

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IVY LAM (646), GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2019_769646_0004
Log No. / No de registre :	003216-17, 004283-17, 012830-17, 002441-18, 002975-18, 008501-18, 008642-18, 024669-18, 033028-18, 033197-18, 001211-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 30, 2019
Licensee / Titulaire de permis :	Delcare LTC Inc. 4800 Dufferin Street, TORONTO, ON, M3H-5S9
LTC Home / Foyer de SLD :	Cawthra Gardens 590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Marriott

Ontario

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

To Delcare LTC Inc., 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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

Specifically, the licensee must:

1. Ensure that all direct care staff (PSWs and Registered staff) use safe transferring and positioning devices or techniques when assisting resident #004;

2. Review with all direct care staff (PSWs and Registered staff) the home's current safe transferring policy and ensure staff fully understand by maintaining an attendance list;

3. Develop, document, and implement quality improvement audits of residents' plans of care to ensure safe transferring and positioning devices or techniques are identified and communicated to all direct care staff. The audit is to include, but is not limited to, the following: unit name, date of audit, person completing the audit, residents' names, assessed transferring and positioning device or technique to be used, outcome of audit, follow up actions; and other relevant information as needed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

The Ministry of Health and Long Term Care (MOHLTC) received a Critical Incident System (CIS) report regarding an incident that happened during transfer which caused an injury to resident #004 and resulted in a significant change in the resident's health status.

A review of the progress notes on the date of the incident indicated that Personal Support Worker (PSW) #119 assisted the resident for toileting care. The PSW transferred the resident using a different method than what was in the resident's written care plan. As the resident and PSW moved towards the washroom, the resident began to display responsive behaviours toward the PSW. The resident lost their balance in the process and fell on the floor, and was sent to the hospital where they were identified to have sustained an injury.

A review of resident #004's Minimum Data Set (MDS) assessment prior to the incident indicated resident #004 required identified assistance by staff for transferring and toileting care. The MDS record also indicated that the resident was resistive and had identified responsive behaviours toward staff members.

A review of the resident's written care plan prior to the incident identified that the resident was at risk for falls due to identified risk factors, including responsive behaviours. The plan of care indicated the resident required assistance by a specific number of staff for identified activities of daily living. The plan for transfer identified a specific number of staff to provide assistance with transfers. Staff members were to use an identified method to assist resident #004 in getting in and out of the bed, especially at identified times when the resident was tired. The care plan indicated that a specific number of staff members were needed when resident #004 was resistive.

A review of the PSW documentation survey record for three identified months up until the date of the incident indicated that resident #004 was assisted to the toilet by the number of staff specified on the resident's written care plan on all three shifts with the exception of 13 identified shifts. The records showed that the staff who signed off on the shifts was PSW #119.

An interview with PSW #119 indicated that they were aware of resident #004's health condition, needs and interventions. The PSW stated that resident #004 required assistance by a specific number of staff, as the resident was resistive to care with identified responsive behaviours. In an initial interview, PSW #119 stated that on the date of the incident when they went to provide toileting assistance to resident #004, another staff, PSW #121, was present. PSW #119 further stated they got the resident up to sit on the edge of the bed and assisted the resident up. The resident got up and began to be resistive to care and fell to

the floor on to an identified side of their body. The PSW was not able to explain how the resident sustained an injury on the opposite side of their body than the side that the PSW said the resident had fallen on, or if the second staff member, PSW #121, saw how the resident fell.

An interview with PSW #121 indicated that at the time of the abovementioned incident, the PSW was providing care for another resident in an identified room which was further down the hall. They heard a "bump" and went to see what happened. The PSW stated they were not in the room where resident #004 resided and had not seen how the resident fell. The PSW also indicated that they were not called to assist resident #004 for toileting, although they were aware that resident #004 needed a specified number of staff members for assistance with bed mobility, transfer, toileting and dressing.

In an interview, Registered Practical Nurse (RPN) #120, indicated that on the day of the incident, they were called by PSW #119 to see resident #004 who was on the floor in their room. The RPN stated that PSW #121 was not in the resident's room on their arrival. Further, the RPN stated that resident #004 had been identified to have responsive behaviours and required assistance by a specified number of staff due to resistiveness with care, and that staff should be aware of the resident's care plan. The RPN further explained the proper transfer techniques and interventions for resident #004 to ensure that the resident was stable prior to ambulating with the resident. If the resident is resistive in the process, the staff was to leave the resident, re-approach them or seek assistance from second staff to provide assistance. The RPN also stated that PSW #119 had told them that during the identified transfer, the resident suddenly demonstrated physical responsive behaviours towards the PSW and the resident lost their balance and fell. Upon review of the resident #004's written plan of care, the RPN agreed that PSW #119 did not safely transfer the resident.

A review of the home's investigation file of the incident showed that PSW #119's initial statement on the date of the incident was that they were ambulating with resident #004 to the washroom. Before reaching the washroom, the resident suddenly displayed responsive behaviours towards the PSW. The PSW moved back and the resident lost their balance and fell, hitting the floor. PSW #119 called RPN #120 and PSW #121 who was in another resident's room.

A second interview with PSW #119 revealed a discrepancy between the CIS report and the PSW's initial written statement of how they assisted resident #004, and their initial interview with the inspector. In the second interview, PSW #119 indicated that they woke resident #004 up, and after assisting the resident to get up, the resident suddenly pulled away from the PSW, fixed their hair and their clothing and extended their hands again towards the PSW to let the PSW hold them. As they began to walk, the resident suddenly pulled away from the PSW, lost their balance, and fell on an identified side, hitting an identified part of their body on the floor. The PSW stated that the resident did not display responsive behaviours toward the PSW. When PSW #119 was asked about the differences in their statement, they said they forgot how it happened. When they were asked if they had followed the plan of care for safe transferring when assisting resident #004 from bed to the toilet, the PSW did not respond.

In an interview, the Director of Care (DOC) acknowledged that PSW #119 did not follow the direction from the plan of care for safe transferring when they assisted resident #004 to the toilet on the abovementioned date.

The severity of this issue was determined to be a level 3 as there was actual harm to resident. The scope was a level 1 isolated, as the risk of harm was related to one resident out of four residents reviewed. The home had a level 2 compliance history as the home has previous unrelated non-compliances in the past 36 months. (600)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2019

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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 30th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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