Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2022	2022_631210_0001	012514-21, 019090-21	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

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

Streetsville Care Community
1742 Bristol Road West Mississauga ON L5M 1X9

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

SLAVICA VUCKO (210)

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): January 12, 13, 14, 17, 18, 19, and 20, 2021.

During the course of the inspection the following Critical Incident System (CIS) reports were inspected:

-intake #01090-21 related to alleged abuse,
-intake #012514-21 related to prevention of falls.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed the home's internal investigation notes, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support workers (PSWs), Behavioral Support Ontario (BSO) Lead, Infection Prevention and Control (IPAC) Lead, and residents.

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

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

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

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term Care

(MLTC) about alleged physical abuse of resident #001 by staff, on a specified date.

Resident #001's care plan indicated the resident required two-person extensive physical assistance for transfers, and if in a specific condition a lift to be used for Activities of Daily Living (ADL).

On a specified date, resident #001 presented with a responsive behaviour, using profane language towards staff. The resident requested to go to the washroom and PSW #107 assisted them. They wheeled the resident to their room, and parked the wheelchair in front of their washroom. The wheelchair did not fit through the washroom door for the resident to be toileted. PSW #107 and #108 transferred the resident from the wheelchair to the toilet, using a method that was not specified in the resident's care plan. The resident was restless while on the toilet, attempting to get up several times and hit the staff while staff tried to change their clothes. After completing the care, the resident was assisted from the toilet to the wheelchair using the same technique.

PSW #107, stated it was a daily routine to transfer the resident for toileting using the method mentioned above.

The home's policy "Safe Resident Handling" VII-G-20.30, dated April 2019, indicated "zero" lifting policy to minimize the risk of injury to care team members and ensure the safety of all residents. Resident's ability to transfer safely depended on the following circumstances: weight bearing ability, ability to communicate, cognition, level of responsive behavior, strength, level of participation and any other changes in status affecting resident's mobility.

As per the Physiotherapist (PT) resident #001 should not be assisted with transferring using the method mentioned above if the resident did not cooperate, exhibited responsive behaviour or if in a specific condition. If this was a case, the staff should have transferred the resident with a lift as per the care plan.

Resident was not transferred and positioned safely during toileting on a specified date.

Sources: review of the CIS report, resident #001's clinical record, home's investigation notes, home's policies and procedures, and interview with Physiotherapist and other staff. [s. 36.]

Additional Required Actions:

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

Issued on this 16th day of February, 2022

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

Original report signed by the inspector.