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
Oct 4, 2019	2019_751649_0015	003953-18, 006033-18, 016345-18, 018218-18, 005234-19, 007722-19, 014564-19, 014659-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Elginwood
182 Yorkland Street RICHMOND HILL ON L4S 2M9

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

JULIEANN HING (649), JOANNE ZAHUR (589), ORALDEEN BROWN (698)

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): August 6, 7, 9, 12, 13, 14, 15, 16, 19, 20, and 23, and off-site on August 21, 26, 27, and 30, 2019.

The following intakes were inspected:
log #003953-18 related to continence care and prevention of abuse and neglect
log #006033-18 related to plan of care
log #016345-18 related to transferring and positioning technique and prevention of abuse and neglect
log #018218-18 related to training and plan of care
logs #005234-19, #007722-19 and #014564-19 related to prevention of abuse and neglect
log #014659-19 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant director of care (ADOC), physician, registered nurses (RNs & RPNs), wound care champion (WCC), registered dietitian (RD), physiotherapist (PT), resident services coordinator (RSC), personal support workers (PSWs), private care companion (PCC), residents and family members.

Note: A Compliance Order related to LTCHA, 2007, 79/10, r. 36 was identified in Inspection report #2019_751649_0016 and has been issued in this Inspection Report, which was conducted concurrently with this inspection.

The inspectors reviewed residents' health records, staffing schedules, staff training records, investigation notes, conducted observations, and reviewed any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

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

5 WN(s)
3 VPC(s)
2 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 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 residents #005, #008 and #003 were protected from abuse.
In accordance with the definition identified in section 2(1) of the Regulation 79/10 "physical abuse" means the use of physical force by a resident that causes physical injury to another resident ("mauvais traitement d'ordre physique").

(i) A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) alleging there was an incident of resident to resident responsive behaviour that resulted in resident #005 sustaining an injury.

A review of resident #005's progress notes indicated that resident #005 exhibited an identified responsive behavior towards resident #006, both residents fell on the floor and as a result resident #005 sustained an injury.

Record review indicated that resident #005 had responsive behaviors the week leading up to the above incident. As a result of their behaviour the home had implemented a monitoring intervention which was started on an identified date on the night shift for resident #005.

A review of the home's investigation notes indicated that the PSW assigned to resident #005 on the night shift was an agency PSW who had been assigned to the resident until a specified time. The agency staff assigned to provide the monitoring to resident #005 left their shift one hour earlier instead of when the shift was scheduled to end, without reporting off to anyone that they were leaving. At an identified time, resident #005 exhibited a responsive behavior towards resident #006 who responded to an identified trigger. Both residents fell on the floor and as a result resident #005 sustained an injury.

The inspector was told that the agency PSW who had been assigned to provide monitoring to resident #005 on the above mentioned night shift had not returned to work at the home and was not available for an interview.

Interview with the DOC acknowledged that resident #005 had identified responsive behaviors that resulted in them exhibiting a responsive behavior towards resident #006 and resulted in resident #005 sustaining an injury.

(ii) Record review of CIS report submitted to the MLTC, indicated there was an incident of resident to resident abuse. According to the CIS report resident #008 exhibited a responsive behaviour towards resident #005 during lunch on an identified date. Resident #008’s behaviour triggered a response from resident #005 resulting in resident #008 sustaining an injury.

During an interview with PSW #116 who had been present when the above incident had occurred, they told the inspector that they were feeding resident #005 when resident #008 came by and began exhibiting an identified responsive behaivour towards resident #005. PSW #116 acknowledged they were a new staff at the time, had gotten up from the table and went over to the servery and when they turned around, they noticed resident #008 holding an identified body area. Upon further assessment resident #008 was observed to have sustained an injury and they immediately called PSW #132 who then alerted the registered staff. PSW #116 further indicated that resident #005 was triggered by certain identified responsive behaviors.

During an interview, PSW #132 indicated that resident #008 had several identified responsive behaviours and that they were monitored and given re-direction. PSW #132 indicated that on an identified date during lunch resident #008 went over to resident #005 and resident #008 exhibited an identified responsive behaivour towards them. This triggered a response from resident #005 resulting in resident #008 sustaining an injury. PSW #132 immediately notified RN #112 who had assessed resident #008.

During interviews with PSWs #138 and #139, they indicated that resident #005 was triggered by an identified responsive behavior. A review of the plan of care for resident #005 did not identify the trigger or an intervention to manage it. The PSWs continued to say that during routine care the resident would have responsive behaviours towards staff members.

During an interview, RN #112 acknowledged that abuse had occurred when resident

#005 had an identified responsive behavior towards resident #008.

Record reviews and interviews indicate that the licensee had failed to protect resident #008 from abuse by resident #005 when resident #008 had wandered over to resident #005 during lunch. Resident #008 exhibited a responsive behavior towards resident #005 which resulted in resident #008 sustaining an injury. The licensee also failed to protect resident #006 from resident #005 when there was an altercation between the two residents resulting in injury to resident #005.

2. As per O. Reg. 79/10., subsection 2 (1) of the Act, abuse is defined as the following:
-emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including lack of acknowledgment and infantilization that are performed by anyone other than a resident,
-physical abuse is defined as the use of physical force by anyone other than a resident that caused physical injury or pain, and
-verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The MLTC received a CIS report which indicated that PSWs #106 and #107 used the mechanical lift for resident #003 and after toileting the resident exhibited responsive behaviours as they were apprehensive with the use of the mechanical lift. The CIS report further indicated the following:
-mechanical lift was being used post toileting, resident #003 was exhibiting responsive behaviour,
- PSW #107 observed PSW #106 grab an identified body area of resident #003's and push them back causing the resident to scream, also PSW #107 observed PSW #106 pointing their finger at the resident and telling them they were bad and to shut up, and
-resident #003 let go of the lift handles when an identified body area was grabbed and pushed back, lost their balance, slipped and was lowered into the wheelchair, sustaining altered skin integrity to an identified body area.

A review of the home's internal investigation notes indicated that PSW #106 denied that any of the above-mentioned incidents had occurred. The investigation notes further indicated the LTCH had initiated disciplinary action against PSW #106. PSW #106 was required to be re-educated on the Resident's Bill of Rights, dementia care, abuse prevention and safe ambulation lift and transfers (SALT) assessments.

During an interview, PSW #107 acknowledged they had observed the above-mentioned incidents and had told PSW #106 to stop what they were doing towards resident #003. PSW #107 further stated that this was no way for a resident to be treated.

PSW #106 is no longer employed by the home therefore an interview was not conducted.

During an interview, DOC #109 who has been in the LTCH since mid-September 2018, acknowledged that PSW #106 had mis-treated resident #003. [s. 19. (1)]

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 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 devices or techniques when assisting residents #012, #003 and #010.

(i) The MLTC received a CIS report for an incident where resident #012 sustained an injury to an identified body area from an identified object during care. The CIS further indicated the resident was transferred to hospital for further assessment of this injury to rule out an identified medical condition. Resident #012 returned to the Long-Term Care Home (LTCH) later the same day with no evidence of an identified medical condition.

During an interview, PSW #102 stated that care and bed mobility was usually provided by one staff. The care plan was updated after the above-mentioned incident to reflect two staff for bed mobility. PSW #102 further stated that on that night, resident #012 was positioned on their side towards an identified object with PSW #102 supporting their back. Resident #012 used their feet to push themselves up in bed when their body made a sudden jerking movement which resulted in them striking an identified body area on an identified object. PSW #102 stated that resident #012 has an identified medical condition

and that is why they made that sudden jerking movement, however as noted above, this medical condition was not identified in resident #012's health record. PSW #102 stated they did not notice the injury until the resident was on their back and noted blood to an identified body area. PSW #102 acknowledged that resident #012 was probably positioned too close to the edge of the bed.

During an interview, DOC #109 who has been in the LTCH since mid-September 2018, acknowledged that it was possible that PSW #102 had not used safe positioning techniques when assisting resident #012.

(ii) The MLTC received a CIS report which indicated that PSWs #106 and #107 used the mechanical lift for resident #003 and after toileting the resident exhibited responsive behaviours as they were apprehensive with the use of the mechanical lift. During the transfer, resident #003 let go of the lift, lost balance, slipped out of the sling and was lowered into the wheelchair by the two PSWs present. The CIS report further indicated that resident #003 sustained altered skin integrity to an identified body area from this incident related to friction from the sling.

During an interview, PSW #107 stated they were assisting PSW #106 with resident #003 and observed that the waist buckle of the sling had not been snapped closed so when resident #003 let go of the lift handles, they lost their balance and slipped from the sling resulting in altered skin integrity to an identified body area. PSW #107 acknowledged that two of the four buckles had not been snapped in place and therefore, unsafe transferring techniques had been used with resident #003.

PSW #106 is no longer employed by the LTCH therefore an interview was not conducted.

An interview with resident #003 was attempted, however, the interview was not completed.

During an interview, DOC #109 stated the LTCH home uses Arjo-Huntleigh lifts and the manufacturer's recommendations on usage indicate the need to snap and buckle all clips on transfer slings when transferring a resident for safety. DOC #109 who has been in the home since mid-September 2018, acknowledged that unsafe transferring techniques had been used when using the mechanical lift with resident #003.

(iii) A complaint was submitted to the MLTC related to concerns of resident #010's repeated injuries and the home's inability to identify their cause.

According to resident #010's progress notes they had sustained several injuries on identified dates.

Resident #010 is no longer in the home. Record review indicated an entry was made by the PT on an identified date that the resident was non-weight bearing and had required the hoyer lift for transfers. A more recent entry made by the PT on another identified date indicated that the resident had to be transferred with the hoyer lift by two staff. Further review of the resident's care plan indicated that the resident required total assistance of two staff for transfers with the use of the hoyer lift.

During an interview with PSW #119, who was assigned to the resident when they had sustained the first injury they told the inspector that the resident had required the use of the hoyer lift with the assistance of two staff for transfers. According to the PSW they did not know how the resident had sustained an injury and stated maybe they had hit the mobility aid but was unsure.

During an interview with PSW #137, who was the second staff assisting with the resident's transfer on an identified date, they told the inspector that the resident had a responsive behavior after the shower that resulted in them sustaining an injury. According to PSW #137 the resident was not on the lift when the injury happened. The PSW told the inspector that they should have been using a different type of mechanical lift for the resident's transfer. They went on to explain that for the resident's showers they would use the identified lift to dress the resident as it was easier for the staff rather than transferring the resident back to bed with the other lift, dress them then transfer again to the mobility aid. The PSW told the inspector that if the resident could not weight bear they would not have used the identified lift.

During an interview with PSW #123, who had been working with the resident for the last several months after there was a change in the PSW's assignment, told the inspector that they had been using the identified mechanical lift to transfer the resident only when they did not demonstrate responsive behaviors on their shower days. According to PSW #123, they thought that the resident was able to weight bear.

During an interview, DOC #109 acknowledged that safe positioning and transferring technique had not been used with resident #010.

During separate interviews with PSW #137 and #123 the inspector was told that they had

been using the identified mechanical lift on the resident's bath days even though the resident was non-weight bearing. Safe transferring and positioning techniques had not been used by staff. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

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 that the care set out in the plan of care was provided to resident #013 as specified in the plan.

The MLTC received a CIS report that indicated PSW #142 was observed taking an identified object away from the resident forcibly without telling resident #013 what they were doing, resulting in the resident sustaining an injury.

A review of the home's internal investigation indicated PSW #142 had approached resident #013 and forcibly grabbed an object from them without asking or telling the resident why they wanted the object. The resident did not let go of the object, but PSW #142 continued to pull at it and when the resident did let go resulted in them sustaining an injury. The investigation concluded that PSW #142's behavior had been unacceptable and showed complete disregard for established company policies, procedures and general performance expectations. The Long-Term Care Home (LTCH) issued disciplinary action towards PSW #142 for their actions towards resident #013. PSW #142

was required to participate in additional training that included Stop, Think, Observe, Plan (STOP), Resident’s Bill of Rights and Responsive Behaviours.

During an interview, the resident services coordinator (RSC) #131 stated that PSW #108 reported to them that they had observed an incident between resident #013 and PSW #142 where PSW #142 was trying to get an object from resident #013 that they were not letting go. PSW #108 further reported that they observed that the resident had sustained an injury and felt it needed to be assessed. PSW #108 also stated they had told PSW #142 to leave and re-approach resident #013 since they were not letting go of the object. RSC #131 further stated they had viewed video surveillance of this incident with a former ADOC and it was clear there was an incident between the resident and PSW #142. The LTCH was unable to provide this video footage at the time of this inspection.

During an interview, PSW #142 stated they had been attempting to get an identified object from resident #013 that they were not letting go. PSW #142 further stated they had wanted to remove the identified object and now knows they should have left resident #013 and re-approached later. PSW #142 acknowledged that they were human and had made a mistake.

During an interview, the DOC #109 acknowledged that PSW #142 had not provided care to resident #013 as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care for resident #014 was documented.

The MLTC received a CIS report related to resident #014 who indicated they had not received an identified intervention from PSW #101 for most of the day shift on an identified date.

Resident #014 had complained to RPN #104 that PSW #101 had only provided the identified intervention in the morning and nothing else for the rest of the shift.

During an interview, PSW #101 stated they had approached resident #014 on several occasions throughout the shift and they had replied they were okay. PSW #101 acknowledged they had only provided the intervention in the morning and had accepted resident #014’s responses as being okay without checking if the identified intervention was needed and had forgotten to endorse this to the oncoming shift.

A review of the Point Click Care (PCC) documentation report indicated that PSW #101 had documented they had provided the identified intervention even though there was an option to indicate it had not been done.

During a follow-up interview with PSW #101, they acknowledged they had not documented accurately that the identified intervention had not been provided.

During an interview, DOC #109 who joined the LTCH in mid September 2018, acknowledged that PSW #101 had failed to ensure that the provision of care set out in the plan of care for resident #014 had been documented accurately. [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 that the care set out in the plan of care is provided to the resident as specified in the plan and ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 resident #007's identified device was maintained in a safe condition and in a good state of repair.

The MLTC received a CIS report related to a fall incident involving resident #007. The CIS report indicated that resident #007 sustained an injury.

During an interview, PSW #114 stated they had been the primary caregiver on the above date and acknowledged that the identified device was not working when they had gotten resident #007 up for breakfast that morning. PSW #114 further stated that it was their duty to have reported that the identified device was not in good repair but cannot explain why it did not enter their mind that day. PSW#114 also stated that it was the physiotherapist and the ADOC who came to the resident's room after the fall incident that discovered the identified device was not in a good state of repair.

During an interview, RPN #115 stated that after the fall incident they changed a part of the identified device because it had not been functioning properly.

During an interview, DOC #109 acknowledged that PSW #114 had failed to ensure that resident #007's identified device, had been maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #005 was based on, at a minimum, interdisciplinary assessment of the mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers, and variations in resident functioning at different times of the day.

Record review of a CIS report submitted to the MLTC alleging that there was a resident to resident incident that resulted in injury. Resident #008 had approached resident #005 in an identified area of the home and exhibited an identified behaviour towards resident #005. This triggered a response from resident #005 resulting in resident #008 sustaining an injury.

Record review of resident #005's progress notes and care plan indicated that resident #005 had a history of identified responsive behaviors. On a previous identified date resident #005 had an interaction with resident #006. Both resident #005 and #006 fell on the floor and resident #005 sustained an injury.

Record review indicated that resident #005 had identified responsive behaviors the week leading up to the first incident. As a result of their behaviour the home had implemented a monitoring intervention which was started on an identified date on the night shift for resident #005.

The specific trigger pertaining to the incident on the previous identified date was not identified in resident #005's care plan.

During interviews with PSWs #138, #139, #143 and RN #112, they stated that resident #005 would have been triggered by identified responsive behaviours.

During an interview with DOC #109, they indicated that resident #005 had triggers that were not identified in their plan of care and acknowledged that resident #005 had responsive behaviors that were triggered causing injury to resident #008.

Resident #005's plan of care did not identify potential behavioural triggers. [s. 26. (3) 5.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

Issued on this 7th day of October, 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

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

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) :	JULIEANN HING (649), JOANNE ZAHUR (589), ORALDEEN BROWN (698)
Inspection No. / No de l'inspection :	2019_751649_0015
Log No. / No de registre :	003953-18, 006033-18, 016345-18, 018218-18, 005234-19, 007722-19, 014564-19, 014659-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 4, 2019
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Elginwood 182 Yorkland Street, RICHMOND HILL, ON, L4S-2M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laura Powell

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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 AXR Operating (National) LP, by its general partners, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 19 (1).

Specifically, the licensee shall ensure that residents #005, #008 and #003 are protected from abuse.

Upon receipt of this compliance order the licensee shall:
1. Update the plan of care for resident #005 to identify any potential responsive behaviour triggers, and include interventions and/or strategies to manage these triggers. Ensure interventions are in place to protect resident #008 and any other resident from abuse by resident #005.
2. Update the plan of care for resident #006 to include interventions and/or strategies to protect them from abuse by resident #005.
3. Provide orientation to all agency staff providing a monitoring intervention to residents to report-in at the start/end of every shift and any breaks as applicable to the nurse in charge.
4. Develop a process to monitor resident #005 and any other residents who exhibit responsive behaviours to prevent altercations with co-residents.
5. The home is to provide PSWs assigned to resident #003 with education on behaviour management, including alternative care approaches, to prevent incidents of staff to resident abuse with resident #003 and any other residents exhibiting responsive behaviours. A record of the education provided must be maintained that includes the topic covered, staff attendance records, date of the education and who provided the education.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #005, #008 and #003 were protected from abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "physical abuse" means the use of physical force by a resident that causes physical injury to another resident ("mauvais traitement d'ordre physique").

(i) A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) alleging there was an incident of resident to resident responsive behaviour that resulted in resident #005 sustaining an injury.

A review of resident #005's progress notes indicated that resident #005 exhibited an identified responsive behavior towards resident #006, both residents fell on the floor and as a result resident #005 sustained an injury.

Record review indicated that resident #005 had responsive behaviors the week leading up to the above incident. As a result of their behaviour the home had implemented a monitoring intervention which was started on an identified date on the night shift for resident #005.

A review of the home's investigation notes indicated that the PSW assigned to resident #005 on the night shift was an agency PSW who had been assigned to the resident until a specified time. The agency staff assigned to provide the monitoring to resident #005 left their shift one hour earlier instead of when the shift was scheduled to end, without reporting off to anyone that they were leaving. At an identified time, resident #005 exhibited a responsive behavior towards resident #006 who responded to an identified trigger. Both residents fell on the floor and as a result resident #005 sustained an injury.

The inspector was told that the agency PSW who had been assigned to provide monitoring to resident #005 on the above mentioned night shift had not returned to work at the home and was not available for an interview.

Interview with the DOC acknowledged that resident #005 had identified responsive behaviors that resulted in them exhibiting a responsive behavior towards resident #006 and resulted in resident #005 sustaining an injury.

(ii) Record review of CIS report submitted to the MLTC, indicated there was an

incident of resident to resident abuse. According to the CIS report resident #008 exhibited a responsive behaviour towards resident #005 during lunch on an identified date. Resident #008's behaviour triggered a response from resident #005 resulting in resident #008 sustaining an injury.

During an interview with PSW #116 who had been present when the above incident had occurred, they told the inspector that they were feeding resident #005 when resident #008 came by and began exhibiting an identified responsive behaivour towards resident #005. PSW #116 acknowledged they were a new staff at the time, had gotten up from the table and went over to the servery and when they turned around, they noticed resident #008 holding an identified body area. Upon further assessment resident #008 was observed to have sustained an injury and they immediately called PSW #132 who then alerted the registered staff. PSW #116 further indicated that resident #005 was triggered by certain identified responsive behaviors.

During an interview, PSW #132 indicated that resident #008 had several identified responsive behaviours and that they were monitored and given re-direction. PSW #132 indicated that on an identified date during lunch resident #008 went over to resident #005 and resident #008 exhibited an identified responsive behaivour towards them. This triggered a response from resident #005 resulting in resident #008 sustaining an injury. PSW #132 immediately notified RN #112 who had assessed resident #008.

During interviews with PSWs #138 and #139, they indicated that resident #005 was triggered by an identified responsive behavior. A review of the plan of care for resident #005 did not identify the trigger or an intervention to manage it. The PSWs continued to say that during routine care the resident would have responsive behaviours towards staff members.

During an interview, RN #112 acknowledged that abuse had occurred when resident #005 had an identified responsive behavior towards resident #008.

Record reviews and interviews indicate that the licensee had failed to protect resident #008 from abuse by resident #005 when resident #008 had wandered over to resident #005 during lunch. Resident #008 exhibited a responsive behavior towards resident #005 which resulted in resident #008 sustaining an

injury. The licensee also failed to protect resident #006 from resident #005 when there was an altercation between the two residents resulting in injury to resident #005.
(698)

2. As per O. Reg. 79/10., subsection 2 (1) of the Act, abuse is defined as the following:
-emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including lack of acknowledgment and infantilization that are performed by anyone other than a resident,
-physical abuse is defined as the use of physical force by anyone other than a resident that caused physical injury or pain, and
-verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The MLTC received a CIS report which indicated that PSWs #106 and #107 used the mechanical lift for resident #003 and after toileting the resident exhibited responsive behaviours as they were apprehensive with the use of the mechanical lift. The CIS report further indicated the following:
-mechanical lift was being used post toileting, resident #003 was exhibiting responsive behaviour,
- PSW #107 observed PSW #106 grab an identified body area of resident #003's and push them back causing the resident to scream, also PSW #107 observed PSW #106 pointing their finger at the resident and telling them they were bad and to shut up, and
-resident #003 let go of the lift handles when an identified body area was grabbed and pushed back, lost their balance, slipped and was lowered into the wheelchair, sustaining altered skin integrity to an identified body area.

A review of the home's internal investigation notes indicated that PSW #106 denied that any of the above-mentioned incidents had occurred. The investigation notes further indicated the LTCH had initiated disciplinary action against PSW #106. PSW #106 was required to be re-educated on the Resident's Bill of Rights, dementia care, abuse prevention and safe ambulation

lift and transfers (SALT) assessments.

During an interview, PSW #107 acknowledged they had observed the above-mentioned incidents and had told PSW #106 to stop what they were doing towards resident #003. PSW #107 further stated that this was no way for a resident to be treated.

PSW #106 is no longer employed by the home therefore an interview was not conducted.

During an interview, DOC #109 who has been in the LTCH since mid-September 2018, acknowledged that PSW #106 had mis-treated resident #003.

The severity of this non-compliance was identified as actual harm, the scope was identified as widespread. Review of the home's compliance history revealed a voluntary plan of correction (VPC) was issued on May 2, 2017, under inspection report #2017_650565_0004 for the non-compliance with the LTCHA, 2007, s. 19. Due to the severity of actual harm and previous non-compliance, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 08, 2020

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 36.

Specifically, the license shall ensure that staff used safe transferring and positioning devices or techniques when assisting residents #012, #003, and #010.

Upon receipt of this compliance order the licensee shall:
1. Provide training to all PSWs and registered staff working in the home on the home's transfer policy. The training should include but not limited to:
(i) safe positioning of residents in bed during the provision of care,
(ii) correct application of transfer slings including the use of the waist buckle on transfer slings and
(iii) use of the correct transfer equipment specified in the residents' plan of care.
A record of the training provided must be maintained that include the topic covered, staff attendance records, date of the education and who provided the education.
2. Conduct audits including on bath/ shower days, and a variety of shifts, of residents who requires the use of a mechanical lift to ensure compliance with the residents' care plans and the home's transfer policy. A record of the audits completed must be maintained that include residents' name and room number, date of the audit including which shift, names of staff who was audited and the name of staff who completed the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #012, #003 and #010.

The MLTC received a CIS report for an incident where resident #012 sustained an injury to an identified body area from an identified object during care. The CIS further indicated the resident was transferred to hospital for further assessment of this injury to rule out an identified medical condition. Resident #012 returned to the Long-Term Care Home (LTCH) later the same day with no evidence of an identified medical condition.

During an interview, PSW #102 stated that care and bed mobility was usually provided by one staff. The care plan was updated after the above-mentioned incident to reflect two staff for bed mobility. PSW #102 further stated that on that night, resident #012 was positioned on their side towards an identified object with PSW #102 supporting their back. Resident #012 used their feet to push themselves up in bed when their body made a sudden jerking movement which resulted in them striking an identified body area on an identified object. PSW #102 stated that resident #012 has an identified medical condition and that is why they made that sudden jerking movement, however as noted above, this medical condition was not identified in resident #012's health record. PSW #102 stated they did not notice the injury until the resident was on their back and noted blood to an identified body area. PSW #102 acknowledged that resident #012 was probably positioned too close to the edge of the bed.

During an interview, DOC #109 who has been in the LTCH since mid-September 2018, acknowledged that it was possible that PSW #102 had not used safe positioning techniques when assisting resident #012.
(589)

2. The MLTC received a CIS report which indicated that PSWs #106 and #107 used the mechanical lift for resident #003 and after toileting the resident exhibited responsive behaviours as they were apprehensive with the use of the mechanical lift. During the transfer, resident #003 let go of the lift, lost balance, slipped out of the sling and was lowered into the wheelchair by the two PSWs present. The CIS report further indicated that resident #003 sustained altered skin integrity to an identified body area from this incident related to friction from the sling.

During an interview, PSW #107 stated they were assisting PSW #106 with

resident #003 and observed that the waist buckle of the sling had not been snapped closed so when resident #003 let go of the lift handles, they lost their balance and slipped from the sling resulting in altered skin integrity to an identified body area. PSW #107 acknowledged that two of the four buckles had not been snapped in place and therefore, unsafe transferring techniques had been used with resident #003.

PSW #106 is no longer employed by the LTCH therefore an interview was not conducted.

An interview with resident #003 was attempted, however, the interview was not completed.

During an interview, DOC #109 stated the LTCH home uses Arjo-Huntleigh lifts and the manufacturer's recommendations on usage indicate the need to snap and buckle all clips on transfer slings when transferring a resident for safety. DOC #109 who has been in the home since mid-September 2018, acknowledged that unsafe transferring techniques had been used when using the mechanical lift with resident #003.

3. A complaint was submitted to the MLTC related to concerns of resident#010's repeated injuries and the home's inability to identify their cause.

According to resident #010's progress notes they had sustained several injuries on identified dates.

Resident #010 is no longer in the home. Record review indicated an entry was made by the PT on an identified date that the resident was non-weight bearing and had required the hoyer lift for transfers. A more recent entry made by the PT on another identified date indicated that the resident had to be transferred with the hoyer lift by two staff. Further review of the resident's care plan indicated that the resident required total assistance of two staff for transfers with the use of the hoyer lift.

During an interview with PSW #119, who was assigned to the resident when they had sustained the first injury they told the inspector that the resident had required the use of the hoyer lift with the assistance of two staff for transfers.

According to the PSW they did not know how the resident had sustained an injury and stated maybe they had hit the mobility aid but was unsure.

During an interview with PSW #137, who was the second staff assisting with the resident's transfer on an identified date, they told the inspector that the resident had a responsive behavior after the shower that resulted in them sustaining an injury. According to PSW #137 the resident was not on the lift when the injury happened. The PSW told the inspector that they should have been using a different type of mechanical lift for the resident's transfer. They went on to explain that for the resident's showers they would use the identified lift to dress the resident as it was easier for the staff rather than transferring the resident back to bed with the other lift, dress them then transfer again to the mobility aid. The PSW told the inspector that if the resident could not weight bear they would not have used the identified lift.

During an interview with PSW #123, who had been working with the resident for the last several months after there was a change in the PSW's assignment, told the inspector that they had been using the identified mechanical lift to transfer the resident only when they did not demonstrate responsive behaviors on their shower days. According to PSW #123, they thought that the resident was able to weight bear.

During an interview, DOC #109 acknowledged that safe positioning and transferring technique had not been used with resident #010.

During separate interviews with PSW #137 and #123 the inspector was told that they had been using the identified mechanical lift on the resident's bath days even though the resident was non-weight bearing. Safe transferring and positioning techniques had not been used by staff.

The severity of this non-compliance was identified as actual harm, the scope was identified as pattern. Review of the home's compliance history revealed a voluntary plan of correction (VPC) was issued on July 17, 2019 , under inspection report #2019_749653_0017 for the non-compliance with the LTCHA, 2007 O. Reg. 79/10, r. 36. Due to the severity of actual harm and previous non-compliance, a CO is warranted. (589)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 08, 2020

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 4th day of October, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : JulieAnn Hing

Service Area Office / Bureau régional de services : Central East Service Area Office