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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 13, 2015	2015_369153_0003	T-1970-15	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE GUILDWOOD
60 GUILDWOOD PARKWAY SCARBOROUGH ON M1E 1N9

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

LYNN PARSONS (153), SAMI JAROUR (570)

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): February 6, 9, 10, 12, 2015.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), clinical coordinator, physiotherapist (PT), personal support workers (PSW), ward clerk and substitute decision-maker (SDM).

The inspectors conducted a tour of the identified home area, observations of video surveillance tapes, staff to resident interactions, provision of care as it relates to transfers with mechanical lifts, record review of clinical health records, staff schedules, staff training records, in-house investigation notes, vulnerable sector criminal reference checks and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with 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 failed to protect resident #01 from physical abuse by anyone. The applicable definition of physical abuse in O. Reg. 79/10 of the LTCHA is "the use of

physical force by anyone other than a resident that causes physical injury or pain."

a) A review of the source material, from identified dates in January 2015, revealed staff #102 repositioned resident #01 in a rough manner to remove the resident's clothing.
Resident #01 protested the actions of staff #102 by clutching arms to chest and kicking lower extremities.
Staff #102 pulled resident #01 forward in a rough manner to apply the lift sling. The resident responded to the application of the sling by kicking lower extremities.
The transfer was completed by staff #102 without the assistance of another staff in attendance.
During the transfer resident #01 was not supported which resulted in the resident being tipped backwards rather than upright for the transfer to the bedside. The resident began fighting the sling and kicking the lower extremities throughout the transfer. While the resident was suspended in the sling over the bed, staff #102 left the bedside to remove the wheelchair to another location in the room. Staff #102 returned to the bedside and provided peri-care while the resident was suspended in the sling and on 2 occasions placed the resident's nightgown over the resident's face and head when the resident verbalized displeasure during the provision of care.

b) A review of the source material, from another identified date in January 2015, revealed staff #102 repositioned resident #01 in a rough manner to remove the resident's clothing.
Resident #01 protested the actions of staff #102 by clutching arms to chest and kicking lower extremities.
Staff #102 washed the resident's upper body with a cloth but did not dry the wet areas and continued to reposition resident #01 in a rough manner in order to apply the lift sling.
The resident became agitated, kicking lower extremities and verbalizing displeasure.
The transfer was completed by staff #102 without the assistance of another staff in attendance.
During the transfer resident #01 was not supported which resulted in the resident being tipped backwards rather than upright for the transfer to the bedside. The resident began fighting the sling and kicking the lower extremities throughout the transfer yelling out and protesting verbally.
Resident #01 was left suspended in the lift over the bed while staff #102 left the bedside and proceeded to the bathroom to obtain paper towels. Upon return to the bedside staff #102 proceeded to provide peri-care while the resident was suspended in the lift.
Resident #01 began screaming and kicking lower extremities.
Staff #102 lowered the lift to lie the resident onto the bed. Resident continued to verbalize displeasure. In response staff #102 removed resident's slacks and placed them

over the resident's nose and mouth.

c) Interviews with the Administrator and DOC confirmed the incidents identified in the source material constituted improper, unsafe care and physical abuse.

2. The licensee failed to ensure that resident #01 was not neglected by the licensee or staff. Neglect is defined in s. 5 of O. Reg. 79/10 as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

a) A review of the source material, from 3 identified dates in January 2015, revealed staff #102 on 3 separate occasions transferred resident #01 from wheelchair to bed with a hoyer lift without the assistance of another staff member.

b) A review of the source material revealed staff #102 on 2 identified dates in January 2015, left the resident suspended in the sling over the bed without locking the lift and left the bedside to relocate the wheelchair on 1 occasion and proceeded to the bathroom on another occasion.

c) On all 3 occasions staff #102 was observed to use a white sling from a bag brought to the resident's room rather than the blue designated sling which was stored in the resident's closet for use when transferring resident #01 with the hoyer lift.

d) Interview with staff #102 confirmed transfers with lifts are completed with two staff or private companion in attendance as per home policy and denied transferring residents on own with a mechanical lift.

e) Interview with staff #108 indicated on some occasions he/she has been present during a transfer with a hoyer lift but only operates the lift controls during a transfer. Staff #108 was unable to confirm being in attendance during transfers involving resident #01 on the identified dates in January 2015.

f) Interviews with Administrator and DOC confirmed resident #01 received improper, unsafe care which constitutes neglect.

g) The employment contract has been terminated for staff #102. [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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
a) Resident #01's plan of care titled rest periods, indicated the following:
- goes to bed around 0730 to 0800
- wakes up around 0800 and 0830.
Interview with staff #104 revealed resident #01 prefers to go to bed between 7:30 p.m. and 8:00 p.m.
Review of the source material revealed staff #102 completed bedtime care and transfer to bed between 6:00 p.m. and 6:55 p.m. on the 3 identified dates in January 2015.
Interview with DOC confirmed the rest periods should have been recorded using the 24

hour clock and did not provide clear directions to staff and others who provide direct care to resident #01.

b) Resident #01's plan of care titled activities of daily living (ADL) related to transfer indicated the following:
- total assistance, mechanical lift with two staff assist using medium sling.
Interviews with PSWs indicated resident #01 requires a small sling when transferred with the hoyer lift.
On February 12, 2015, inspector #153 observed staff #103 and #109 transfer resident #01 from wheelchair to bed and unto the commode using a small sling that was obtained from the resident's closet.
Interview with staff #109 confirmed resident #01 requires the use of a small sling when transferred by hoyer lift.
Interview with the DOC revealed an audit was completed in October 2014, to ensure residents' were transferred with the identified mechanical lift using the appropriate size of sling for each resident.
Interview with the DOC confirmed the plan of care for resident #01 did not provide clear direction to staff who provide direct care in relation to transfer procedures and size of sling to be utilized. [s. 6. (1) (c)]

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

a) A review of the plan of care for resident #01 under the behaviour section, indicated staff to provide concise explanations of care and treatment to resident prior to initiating.
A review of the source material revealed staff #102 provided care to resident #01 without explaining the care the staff was going to provide.
Resident #01's response to the care provided by staff #102 was to yell out and kick lower extremities.
On February 12, 2015, at 1:15 p.m., inspector #153 observed 2 staff transfer resident #01 from wheelchair to bed and then onto the commode chair with a hoyer lift. During the transfer staff #103 and staff #109 conversed between themselves but did not explain the care they were going to provide the resident until such time as resident #01 began to squirm while sitting on the commode chair. The resident settled once informed he/she was sitting on the toilet.
Both staff confirmed they should have informed the resident before providing care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

a) Review of clinical records for resident #01 indicated in October 2014, the resident's transfer status was assessed by the physiotherapist staff #101 as a hoyer lift with 2 person assist with a medium sling. The physiotherapist's recommendation was conveyed to the clinical coordinator staff #105.

Review of plan of care in effect at time of incident indicated that resident #01 requires:
- total assistance with transfers with Mechanical Lift and 2 staff using medium sling
- extensive assistance for toileting using sit to stand lift.

Review of policy entitled "Safe with Care Program" dated May 2009, document #01-02 identifies the Sit-to-Stand Lift support part of the resident's weight but resident's feet touch the foot plate and resident requires some upper extremity strength to support themselves.

On February 6, 2015, at 13:30 p.m. inspector #570 observed PSW staff #100 and staff #103 using sit to stand lift to transfer resident #01 from wheelchair to commode chair for toileting. During the transfer, resident #01 did not appear to be weight bearing and was hanging from the sling unable to use both hands to hold the lift arms.

PSWs interviewed indicated that they could not tell the size of the sling used with the hoyer lift when transferring resident #01 and the assigned sling size is too big for the resident.

RPN staff #105 during an interview indicated that the sit to stand lift should not be used for this resident and the home goes with the physiotherapist's recommendation of the transfer status of the resident. The medium size sling used with the hoyer lift is not the correct size for resident #01 and a smaller size sling should be used according to resident #01's weight and the sling sizing guideline chart used by the home.

The physiotherapist staff #101 confirmed that the sit to stand lift should not be used for resident #01 and correct size of the hoyer lift sling should be small size.

Resident #01 was not assessed and plan of care was not updated when the resident's care needs changed related to sling size and the continued use of the sit to stand lift. [s.

6. (10) (b)]

4. b) Resident #01's plan of care for the ADL section related to dressing indicated the following:
- allow resident to decide what the resident would like to wear
- one staff extensive assistance: staff to assist with the process of dressing
- resident able to lift limbs, identified arm, that was fractured is weak so staff to dress resident, most times total assistance.

A review of the Minimum Data Set (MDS) assessment completed December 2014, revealed the resident required extensive assistance with 1 staff for dressing and a cognitive performance score (CPS) of 6.
Interviews with the DOC and SDM confirmed resident #01 is no longer able to participate in the decision of what to wear due to significant cognitive impairment.
A review of the clinical health record revealed a previous fracture of the resident's opposite arm in 2011, and not the arm indicated in the plan of care.
Interviews with the DOC and SDM confirmed the resident's identified arm was previously fractured and that the plan of care was not assessed and revised.

c) Resident #01's plan of care for the ADL section related to personal hygiene indicated the following:
- sometimes is cooperative and washes own face.

A review of MDS assessment completed in December 2014 revealed the resident required extensive assistance with 2 staff for personal hygiene.
Interviews with PSW staff and SDM confirmed resident is no longer able to wash own face.

d) Resident #01's plan of care for the ADL section related to toilet use indicated the following:
- extensive assistance, staff transfer on and off the toilet/commode using sit/stand lift
- provide peri care, change brief, adjust clothing.

Interviews with PSWs identified a discrepancy in the type of lift to use for transfer purposes.
Observations of transfer process completed on February 6 and 12, 2015, revealed inconsistencies in regards to the type of lift to be used when transferring resident #01.
Interview with the DOC confirmed the plan of care for resident #01 had not been revised when the resident was reassessed in October 2014 , by PT to require the hoyer lift for transfer and not the sit to stand lift. [s. 6. (10) (b)]

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:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
- the care set out in the plan of care is provided to the resident as specified in the plan
- the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that improper care and abuse of a resident occurred did not immediately report the suspicion and the information upon which it was based to the Director, in relation to the following:

a) On February 3, 2015, at 10:00 a.m., the POA for resident #01 met with the Administrator and DOC to review source material, from identified dates in January 2015, which revealed improper, unsafe care and neglect of the resident's health, safety and well-being.

b) On February 4, 2015, the POA for resident #01 met again with the Administrator and DOC to review source material, from another date in January 2015, which revealed improper, unsafe care and physical abuse which caused discomfort to the resident.

c) Interviews with both the Administrator and DOC confirmed the incidents contained in the source material constituted improper, unsafe care and physical abuse.

d) Interview with the Administrator revealed the Director was notified via the after hours pager the following day, late in the afternoon.

e) The Administrator confirmed the Director was not notified immediately upon becoming aware of the incidents of improper, unsafe care and neglect.

f) The Administrator confirmed awareness of the legislative requirement to notify the Director immediately but did not do so due to involvement in the internal investigation. [s. 24. (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 a person who has reasonable grounds to suspect that improper care and abuse of a resident occurred immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: 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 use safe transferring and positioning devices or techniques when assisting residents.

Critical Incident Report (CIR) #2164-000010-15 identifies video recordings from resident #01’s room for identified dates in January 2015, that indicate that PSW staff #102 used a hoyer lift to transfer resident #01 on his/her own without seeking help.

Review of plan of care in effect at time of incident indicated that Resident #01 requires:
- total assistance with transfers with Mechanical Lift and 2 staff using medium sling.
- extensive assistance for toileting using sit to stand lift.

Review of policy entitled "Safe with Care Program" dated May 2009 document #01-02 indicates: "Two trained staff are required at all times when performing a Mechanical Lift”.

Interview on February 6, 2015, with PSW staff #102 indicated that a hoyer lift with 2 staff assist is used to transfer and toilet resident #01. PSW staff #102 indicated he/she will call the private caregiver who assists another resident to help he/she with the transfer.

On February 6, 2015, at 13:30 p.m. inspector observed PSWs staff #100 and staff #103 using sit to stand lift to transfer resident #01 from wheelchair to commode chair for toileting. During the transfer, resident #01 did not appear to be weight bearing and was hanging from the sling unable to use both hands to hold the lift arms.

During an interview PSWs staff #104 and staff #102 indicated that they have not used the sit to stand lift to transfer resident #01 because the resident is unable to hold onto the bars with his/her hands and does not weight bear.

Interviews with the physiotherapist staff #101 and RPN staff #105 indicated that the sit to stand lift should not be used to transfer resident #01 who is not able to weight bear and is prone to skin tears and bruises.

A review of the source material, from identified dates in January 2015, revealed staff #102 on 3 separate occasions transferred resident #01 from wheelchair to bed with a hoyer lift without the assistance of another staff member and used a white sling from a bag brought to the resident's room rather than the blue designated sling which was stored in the resident's closet for use when transferring resident #01 with the hoyer lift.

A review of the source material revealed staff #102 on 2 identified dates in January 2015, left the resident suspended in the sling over the bed without locking the lift and left the bedside to relocate the wheelchair on 1 occasion and proceeded to the bathroom on another occasion.

Transferring resident #01 without required assistance from trained staff and using inappropriate lift puts the resident at risk of injury. [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.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

a) A review of the source material from 2 identified dates in January 2015, revealed the following:
- staff #102 wore a pair of gloves throughout the entire process of undressing resident #01, applying lift sling from a bag brought to the resident's room, not obtaining the resident's personal sling in the closet, transfer to bed, removal of soiled incontinent brief, discarded soiled incontinent brief on the seat of resident's wheelchair, provided peri-care, dressed resident in nightclothes while touching various equipment and items in the room prior to removing the gloves.

b) A review of the source material from another date in January 2015, revealed the following:
- staff #102 wore a pair of gloves throughout the entire process of undressing resident #01, applying lift sling from a bag brought to the resident's room, not obtaining the resident's personal sling in the closet, transfer to bed, removal of soiled incontinent brief, discarded soiled incontinent brief on sheets at the foot of the resident's bed, provided peri-care, dressed resident in nightclothes while touching various equipment and items in the room prior to removing gloves.

c) Interview with the DOC confirmed improper glove use and inappropriate infection control practices by staff #102. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program as it relates to proper use of gloves and appropriate disposal of soiled incontinent products, to be implemented voluntarily.

Issued on this 26th day of March, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNN PARSONS (153), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2015_369153_0003
Log No. / Registre no:	T-1970-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 13, 2015
Licensee / Titulaire de permis :	EXTENDICARE TORONTO INC 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE GUILDWOOD 60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANDRE BARROS

To EXTENDICARE TORONTO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 shall:
1. Develop and implement a system to review all residents who require transfer via mechanical lift to ensure the type of mechanical lift is identified along with the type and size of sling to be used to ensure the safe transfer of residents.
2. Develop resident specific plans of care that provide clear direction to staff regarding the type of mechanical lift and sling to be used for transfer activities.
3. Develop and implement a system to monitor resident transfers using a mechanical lift to ensure 2 staff are always in attendance throughout the entire transfer process.

The Licensee shall prepare, submit and implement a plan for complying with Orders 1 - 3 and identify who will be responsible for completing all of the tasks identified in these Orders and when the Orders with be complied with.

This plan is to be submitted via email to inspector - M.Lynn.Parsons@ontario.ca by March 31, 2015. The date for complying with Orders 1 - 3 shall not be later than April 30, 2015.

Grounds / Motifs :

1. The licensee failed to protect resident #01 from physical abuse by anyone
The applicable definition of physical abuse in O. Reg. 79/10 of the LTCHA is "the use of physical force by anyone other than a resident that causes physical injury or pain."

a) LTCHA s.19.1 was previously issued as a Voluntary Plan of Corrective Action for inspection #2014_251512_022 on December 8, 2014.

b) A review of the source material, from identified dates in January 2015, revealed staff #102 repositioned resident #01 in a rough manner to remove the resident's clothing. Resident #01 protested the actions of staff #102 by clutching arms to chest and kicking lower extremities.
Staff #102 pulled resident #01 forward in a rough manner to apply the lift sling. The resident responded to the application of the sling by kicking lower extremities.
The transfer was completed by staff #102 without the assistance of another staff in attendance.
During the transfer resident #01 was not supported which resulted in the resident being tipped backwards rather than upright for the transfer to the bedside. The resident began fighting the sling and kicking the lower extremities throughout the transfer. While the resident was suspended in the sling over the bed, staff #102 left the bedside to remove the wheelchair to another location in the room. Staff #102 returned to the bedside and provided peri-care while the resident was suspended in the sling and on 2 occasions placed the resident's nightgown over the resident's face and head when the resident verbalized displeasure during the provision of care.

c) A review of the source material, from another date in January 2015, revealed staff #102 repositioned resident #01 in a rough manner to remove the resident's clothing. Resident #01 protested the actions of staff #102 by clutching arms to chest and kicking lower extremities.
Staff #102 washed the resident's upper body with a cloth but did not dry the wet areas and continued to grab resident #01 in a rough manner to change the resident's position in order to apply the lift sling. The resident became agitated, kicking lower extremities and verbalizing displeasure.
The transfer was completed by staff #102 without the assistance of another staff in attendance.
During the transfer resident #01 was not supported which resulted in the resident being tipped backwards rather than upright for the transfer to the bedside. The resident began fighting the sling and kicking the lower extremities throughout the transfer yelling out and protesting verbally.
Resident #01 was left suspended in the lift over the bed while staff #102 left the bedside and proceeded to the bathroom to obtain paper towels. Upon return to the bedside staff #102 proceeded to provide peri-care while the resident was suspended in the lift.
Resident #01 began screaming and kicking lower extremities.
Staff #102 lowered the lift to lie the resident onto the bed. Resident continued to

verbalize displeasure. In response staff #102 removed resident's slacks and placed them over the resident's nose and mouth.

d) Interviews with both the Administrator and DOC confirmed the incidents identified on the source material constituted improper, unsafe care and physical abuse.

2. The licensee failed to ensure that resident #01 was not neglected by the licensee or staff. Neglect is defined in s. 5 of O. Reg. 79/10 as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

a) A review of the source material, from 3 identified dates in January 2015, revealed staff #102 on 3 separate occasions transferred resident #01 from wheelchair to bed with a hoyer lift without the assistance of another staff member.

b) A review of the source material revealed staff #102 on another date in January 2015, left the resident suspended in the sling over the bed without locking the lift and left the bedside to relocate the wheelchair on one occasion and proceed to the bathroom on another occasion.

c) On all 3 occasions staff #102 was observed to use a white sling from a bag brought to the resident's room rather than the blue designated sling which was stored in the resident's closet for use when transferring resident #01 with the hoyer lift.

d) Interview with staff #102 confirmed transfers with lifts are completed with two staff or private companion in attendance as per home policy.

e) Interview with staff #108 indicated on some occasions he/she has been present during a transfer with a hoyer lift but only operates the lift converter. Staff #108 was unable to confirm being in attendance during transfers involving resident #01 on the identified dates in January 2015.

f) Interviews with Administrator and DOC confirmed resident #01 received improper, unsafe care which constitutes neglect.

g) The employment contract has been terminated for staff #102. (153)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

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

Issued on this 13th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNN PARSONS

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