Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 14, 2014	2014_230134_0007	O-00029-14, O-001238-13	Critical Incident System

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE WEST END VILLA
2179 ELMIRA DRIVE, OTTAWA, ON, K2C-3S1

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4 and 5, 2014

During the course of this inspection 2 complaint inspections log #O-000084-14 and #O-001190-13, were conducted.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), several Registered Practical Nurses (RPN), several Personal Support Workers and one resident.

During the course of the inspection, the inspector(s) reviewed residents' health records, toured the unit, reviewed the licensee's Zero Lift policy, the Safe Lifting with Care Program - Document #01-02 and 01-03, the home's internal investigation notes and two critical incident reports.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend 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 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 failed to comply with the O. Reg 79/10 s.36, whereby safe transferring techniques were not used when assisting Resident #10 from bed to chair.

The licensee has a history of non compliance with O. Reg 79/10 s.36. During two inspections, conducted in March 2012 and April 2013, non-compliance related to section 36 was found. As a result of both inspections, the licensee was issued a written notification with the additional required action of a Voluntary Plan of Correction.

Resident #10's health records were reviewed. On a specified date in January, 2014, there is a chart entry indicating Resident #10 had sustained a shearing injury on the left lower calf to the depth of adipose tissue during a transfer from bed to wheelchair. The injury resulted in sutures being required.

On March 4, 2014 Inspector #134 interviewed the DOC, who indicated that after a thorough investigation into Resident #10's injury, it was determined that a staff member had transferred the resident using the transfer lift without assistance.

On March 4, 2014, staff member #100 was interviewed by inspector #134 and reported he/she was on duty the day the injury to Resident #10's leg was reported. He/she acknowledged that he/she had transferred Resident #10 using the ceiling lift by himself/herself but that there was a PSW standing at the door serving as a "spotter" and overlooking the transfer. He/she indicated that due to the busy workload of his/her peers, many will serve as spotters by overlooking the transfer being done.

On March 5, 2014, Inspector #134 interviewed Staff member #101, who reported he/she was on duty on the specified date in January, 2014 and had been called to assist staff member #100 with the lift transfer of Resident #10. He/She said that when he/she arrived to the room the resident was already hooked up to the ceiling lift and was at the foot of the bed ready to be lowered into the wheelchair. He/She indicated that staff member #100 had the remote control and lowered the resident in the wheelchair by himself/herself, that he/she remained at the door and watched him/her complete the transfer. He/she indicated that he/she did not help lower Resident #10 in the chair and that once the resident was sitting in the wheelchair, he/she left the room.

Resident #10's care plan was reviewed. There is an entry indicating the resident was no longer weight bearing and needed a ceiling lift.

On March 5, 2014, Inspector #134 interviewed Resident #12, who used to reside on the unit where the incident occurred. The resident was asked about transferring techniques used by staff on that unit. He/she reported that he/she had witnessed his/her former roommate being transferred using the ceiling lift. He/she reported that some PSWs would transfer his/her roommate by themselves. He/she added that his/her roommate did not like it as he/she was afraid of falling out of the lift.

The inspector reviewed the home's "Safe Lifting with Care Program" - document # 01-02 and 01-03. There is an entry on page 1 of 2 that specifies: "Two trained staff is required at all times when performing a mechanical lift". In document number 01-03 under the Transfer section on page 3 of 5, bullet 15 there is a statement - "N.B. Two people are required at all times. Under bullet 17 - there is an entry that specifies: Both staff members will grasp and pull on the loops of the sling to ensure they are secure. Under bullet #18 - Both staff members complete the 6 point checklist attached to the lift. There is an entry under bullet 22, indicating to use the second person to steady the resident".

Inspector #134 reviewed several pictures of Resident #10's wheelchair and of the wound on his/her left leg. These pictures were taken on the morning of a specified date in January, 2014, where blood was observed on the left foot pedal of the resident's wheelchair.

The unsafe transfer, as described above, for Resident #10, resulted in actual harm to the resident. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 14th day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, LTCH Inspector #134

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2014_230134_0007
Log No. / Registre no:	O-00029-14, O-001238-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 14, 2014
Licensee / Titulaire de permis :	NEW ORCHARD LODGE LIMITED 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE WEST END VILLA 2179 ELMIRA DRIVE, OTTAWA, ON, K2C-3S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KELLY CLOUTIER

To NEW ORCHARD LODGE LIMITED, 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 :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with section 36, to ensure actions are taken to protect residents from injury during transfers. The plan must outline the immediate steps that will be taken to ensure resident safety with regards to lifts and transfers. This plan must include but not be limited to the provision of re-education to all nursing staff as it relates to safe transferring techniques as per the licensee's "Safe Lifting with Care Program" - document # 01-02 and 01-03. This education must include a return demonstration with all lifts in use in the home and with all different styles of transfer slings in use in the home. This education, including return demonstrations, must be completed by June 16, 2014 and documented.
The plan must also outline how the licensee will ensure that there is ongoing monitoring of compliance, with the licensee's safe transfer policy, by way of periodic observation of PSWs' transfer techniques by Registered Nursing Staff on all shifts.

This plan must be submitted in writing to Inspector Colette Asselin at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 613 569-9670 on or before March 24, 2014. Full compliance with this order shall be June 16, 2014.

Grounds / Motifs :

1. The licensee failed to comply with the O. Reg 79/10 s.36, whereby safe transferring techniques were not used when assisting Resident #10 from bed to chair.

The licensee has a history of non compliance with O. Reg 79/10 s.36. During two inspections, conducted in March 2012 and April 2013, non-compliance related to section 36 was found. As a result of both inspections, the licensee

was issued a written notification with the additional required action of a Voluntary Plan of Correction.

Resident #10's health records were reviewed. On a specified date in January, 2014, there is a chart entry indicating Resident #10 had sustained a shearing injury on the left lower calf to the depth of adipose tissue during a transfer from bed to wheelchair. The injury resulted in sutures being required.

On March 4, 2014 Inspector #134 interviewed the DOC, who indicated that after a thorough investigation into Resident #10's injury, it was determined that a staff member had transferred the resident using the transfer lift without assistance.

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Resident #10's care plan was reviewed. There is an entry indicating the resident was no longer weight bearing and needed a ceiling lift.

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themselves. He/she added that his/her roommate did not like it as he/she was afraid of falling out of the lift.

The inspector reviewed the home's "Safe Lifting with Care Program" - document # 01-02 and 01-03. There is an entry on page 1 of 2 that specifies: "Two trained staff is required at all times when performing a mechanical lift". In document number 01-03 under the Transfer section on page 3 of 5, bullet 15 there is a statement - "N.B. Two people are required at all times. Under bullet 17 - there is an entry that specifies: Both staff members will grasp and pull on the loops of the sling to ensure they are secure. Under bullet #18 - Both staff members complete the 6 point checklist attached to the lift. There is an entry under bullet 22, indicating to use the second person to steady the resident".

Inspector #134 reviewed several pictures of Resident #10's wheelchair and of the wound on his/her left leg. These pictures were taken on the morning of a specified date in January, 2014, where blood was observed on the left foot pedal of the resident's wheelchair.

The unsafe transfer, as described above, for Resident #10, resulted in actual harm to the resident. [s. 36.] (134)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** Jun 16, 2014

Ministry of Health and Long-Term Care

Ministère 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

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.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 14th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Colette Asselin RN

Name of Inspector / Nom de l'inspecteur : COLETTE ASSELIN

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