Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 10, 2020	2020_822613_0008	001658-20	Complaint

Licensee/Titulaire de permis

F. J. Davey Home
733 Third Line East Sault Ste Marie ON P6A 7C1

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

F. J. Davey Home
733 Third Line East SAULT STE. MARIE ON P6A 7C1

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

LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Febraury 24 - 28, 2020 and March 2, 2020.

The following complaint was inspected during this inspection:

One Complaint that was submitted to the Director regarding allegations of improper care following a resident fall resulting in an injury and transfer to the hospital.

A concurrent Critical Incident System Inspection #2020_822613_0009 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Administrator (EADM), Executive Director of Care (EDOC), Directors of Care (DOCs), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed video surveillance, personnel files, health care records, internal investigation files and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1., the licensee was required to ensure that the falls prevention and management interdisciplinary program was developed and implemented to reduce the incidence of falls and risk of injury.

Specifically, staff did not comply with the following licensee's policies:

A) "Falls Prevention and Management Program" (RC-15-01-01) last updated December 2019, which identified that care staff would 1) report any incidents of a resident found on the floor or resident fall immediately to the nurse, 2) ensure that prior to a resident being transferred or assisted to ambulate post-fall, the resident was assessed by a nurse, 3) transfer the resident post-fall, unless, the resident was able to get up on their, and only after the nurse had assessed the resident and approved the transfer.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying resident #001 had a fall and sustained an injury. The CI report revealed that PSW #107 had witnessed the resident fall on a specific date and that resident #001 was transferred to the hospital.

The Inspector reviewed a complaint report that was received by the Director, alleging that PSW #107 had provided improper care to resident #001, following their fall on a specific date.

Inspector #613 viewed the home's video surveillance that identified resident #001 had a fall on a specific date and time. PSW #107 witnessed the resident fall and approached the resident and knelt to their level and then rolled the resident from their right side to a sitting position, on the floor. The PSW moved behind the resident, putting both of their arms under resident #001's armpits and moved the resident closer to them, so that the resident's back was against the front of their body. The PSW proceeded to turn resident #001 to the right with their arms remaining underneath the resident's armpits and manually pulled resident #001 across the floor while the resident was in a seated position, towards the wall. The video surveillance at a specific date and time, revealed PSW #107 had brought a specific equipment to where the resident was in a sitting position with their back propped up against the wall and applied a specific device to the resident by themself. PSW #107, PSW #109, PSW #111 and RPN #105 were now present on the video surveillance and RPN #105 was completing and assessment on resident #001. A couple minutes later, the video surveillance showed PSW #107 and PSW #109 transporting resident #001 down the hallway using a specific equipment. Resident #001 was in the specific device attached to the specific equipment. RPN #105 and PSW #111 were present during the transfer of resident #001. Later, the video surveillance showed that RN #104 arrived at the unit and ambulated down the hallway, in the direction where resident #001 had been transported by PSW #107 and PSW #109.

The Inspector observed the unit where the resident had fallen and noted that there was a staff assist button located on the wall near where the resident had fallen.

During an interview with PSW #107, they informed the inspector that they had witnessed the resident fall. The PSW stated they did not notify the RPN immediately of the resident's fall; that they did not push the staff assist button and that they could not recall if they had used their portable phone to contact the RPN. PSW #107 stated they had moved resident #001 from a right side lying position on the floor to a sitting position, then moved the resident across the floor, while they were in a sitting position to the wall. The PSW confirmed that they had moved the resident before the RPN arrived at the unit and that they had not received permission to move resident #001.

During an interview with PSW #111, they informed the Inspector that they had heard a noise and a voice calling out, "help me" and arrived at the unit where resident #001 had fallen. The PSW stated they observed PSW #107 positioned behind resident #001, with their arms under the resident's arms and then pulled resident #001 across the floor, while the resident was in a sitting position, and propped the resident with their back against the wall. PSW #111 stated that the resident should not have been moved after falling

onto the floor. The PSW further stated that they notified RPN #105 of the resident fall, as PSW #107 had not.

During an interview with RPN #105, they stated that PSW #107 had not notified them of the resident fall immediately. The RPN stated that PSW #107 had not telephoned them nor pushed the staff assist button. RPN #105 further stated they were not sure if PSW #107 had their portable phone with them, when the fall occurred. The RPN stated when they arrived at the unit that resident #001 was in a sitting position with their back against the wall, in the lounge area. The RPN further stated that they had informed PSW #107 that they were not to move a resident after a fall, until an assessment had been completed by a registered staff.

During an interview RN #104, they stated that PSWs were expected to ensure that a resident was safe following a fall and that they were to immediately notify registered staff of a fall, using the staff assist button or using their portable phones. RN #104 stated PSWs were not to move a resident that had a fall until direction was provided by the registered staff.

During interviews with the EDOC and DOC #100, they stated that PSWs were expected to notify the registered staff immediately with a resident fall. The EDOC and DOC #100, confirmed that PSW #107 should not have moved resident #001 following their fall and not until permission had been provided by the registered staff. They confirmed that PSW #107 did not follow the licensee's falls prevention and management program policy.

B) "Mechanical Lifts Procedure:" (LP-01-01-02) last updated August 2019, which identified 1) two people were required at all times during a resident transfer with a mechanical lift. Two people were required to insert/apply the sling, centre resident with the sling and position the resident arms inside the sling and two staff members were required to remove the sling from underneath the resident. 2) In all situations the resident would be transferred over the shortest distance possible. Under no circumstances would a resident be transported using a mechanical lift (across a room, down a hallway, etc.).

During an interview with PSW #107, they confirmed they had applied the specific device to resident #001 by themself and that they and PSW #109 had transported resident #001 for a specific distance, using a specific equipment. PSW #107 stated that they had received training on safe lifting and transferring and on the use of all types of mechanical lifts. The PSW further stated that they and PSW #109 did not follow the licensee's mechanical lift procedure policy.

During interviews with PSW #111 and RPN #105, they stated that two staff members were required to be present when using the specific equipment, including applying a specific device. Both staff members stated they had received training on safe transferring using a mechanical lift. RPN #105 confirmed that a resident should not be transported using the specific equipment.

During interviews with the EDOC and DOC #100, they both stated that PSW #107 and PSW #109 did not follow safe transferring when transporting resident #001, using the specific equipment and that staff did not follow the licensee's mechanical lift policy. DOC #100 further stated that PSW #107 should not have applied the specific device to resident #001.

C) "Safe Lifting with Care Program (LP-01-01-01)" last updated August 2019, identified that 1) Extendicare was a zero lift facility and that the zero lift program was now integrated with the safe lifting with care program. The zero lift system was designed to eliminate all manual resident lifting and handling through the use of appropriate devices, for the purposes of improving resident quality of life and reducing injuries to staff. 2) All breaches of the Mechanical Lift policy or procedure would result in an investigation and may result in progressive discipline up to and including termination.

A review of the home's internal investigation file revealed a hand written note dated on a specific date, and signed by RN #104 and PSW #107. The note identified that RN #104 had spoken to PSW #107. There was no documentation in the file to identify that an investigation had been done following the staff's breaches of the mechanical lift policy and procedure, following the fall of resident #001 on a specific date.

During interviews with RPN #105, PSW #107 and PSW #111, they all stated that management had not spoken to them regarding the fall of resident #001. They stated they were aware that the home had a zero lift policy and that they could not manually move, handle or lift a resident. All staff interviewed stated they had received training and education on the licensee's falls prevention and management program, mechanical lift procedures and safe lifting with care program.

During an interview with RN #104, they stated that PSW #111 had written a statement of their observations regarding the incident. The RN stated they read the written statement then threw the paper in the garbage.

During an interview with DOC #100, they stated they had been informed of resident #001's fall by RN #104, following the incident and resident #001's transfer to hospital. The DOC further stated that they had viewed the video surveillance involving the incident, the following day. DOC #100 informed the Inspector that they had not investigated the incident and that they had not spoken with any staff member that were involved with the incident.

During an interview the EDOC, they stated that RN #104 should have kept the written statement that had been provided by PSW #111 and that the written statement should have been part of the investigation to this incident and kept in the home's internal file.

During interviews with the Executive Administrator (EADM) and Executive Director of Care (EDOC), they stated they were not aware of the circumstances involved following resident #001's fall or the staff's breaches of the licensee policies until they were informed by Inspector #613, during this inspection. The EADM and EDOC stated they would be investigating this incident further and speaking with all staff involved to prevent recurrence. [s. 8. (1) (a),s. 8. (1) (b)]

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 :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying resident #001 had a fall and sustained an injury. The CI report revealed that PSW #107 had witnessed the resident fall on a specific date. Resident #001 was transferred to the hospital.

The Inspector reviewed a complaint report that was received by the Director, alleging that PSW #107 had provided improper care to resident #001, following their fall on a specific date.

Refer to WN #1 for further information.

A) During an interview with PSW #111, they stated they had observed PSW #107 positioned behind resident #001, while they were in a sitting position on the floor. The PSW stated that PSW #107 had their arms under the resident's arms and pulled resident #001 across the floor while the resident was in a sitting position and then propped them with their back against the wall. PSW #111 stated that resident #001 should not have been moved after falling onto the floor.

During an interview with PSW #107, they stated that they had received training on safe transferring with care and mechanical lifts. The PSW stated that they had manually moved resident #001, themself, across the floor, so they would be more comfortable and would have something to lean against. PSW #107 verified that they should not have lifted the resident manually across the floor.

During interviews with the Executive Director of Care (EDOC) and Director of Care (DOC) #100, they both confirmed that PSW #107 should not have manually moved resident #001 across the floor. They both confirmed that PSW #107 did not follow the licensee's Safe Lifting with Care Program policy.

B) During an interview with PSW #107, they confirmed they had applied a specific device to resident #001 by themself and that they were attempting to position the resident in the specific device and attach it to the specific equipment before RPN #105 had arrived at the unit. The PSW stated they had received training on safe transferring with care and mechanical lifts. PSW #107 informed the Inspector that a PSW could apply a specific device to a resident themself.

During interviews with RPN #105 and PSW #111, they stated that they had observed PSW #107 applying a specific device on resident #001, by themself and that they were in the process of hooking the resident up to the specific equipment. RPN #105 stated they informed PSW #107 to stop as the resident needed to be assessed by them, prior to moving resident #001. RPN #105 and PSW #111 informed the Inspector that two staff members were required to be present to apply a specific device to a resident and through the entire transfer process. Both staff members stated they had received recent training

on safe transferring care program and using mechanical lifts.

During an interview with DOC #100, they stated PSW #107 should not have applied the specific device to resident #001, as the resident should have been assessed by the RPN before any movement of the resident occurred.

C) Inspector #613 observed that resident #001's room was located a far distance from where they had fallen.

During an interview with PSW #107, they confirmed that they had transported resident #001 in the specific equipment from a specific area to the resident's room, with the assistance of PSW #109. The PSW could not recall if RPN #105 had provided direction for this transfer. PSW #107 initially informed the Inspector that they were permitted to transport a resident using a specific equipment, then later stated it was not appropriate.

During an interview with PSW #111, they stated that they were present when PSW #107 and PSW #109 had transported resident #001, using specific equipment, from a specific area to their room.

During an interview with RPN #105, they stated that they were present when PSW #107 and PSW #109 had transported resident #001, using the specific equipment, from a specific area to their room. RPN #105 further stated that they should not have done this and that they did not follow safe transferring when transporting resident #001.

During an interview with RN #104, they stated they were unaware that resident #001 had been transferred to their room using the specific equipment. They further stated that this was too far of a distance to transport resident #001, using the specific equipment. RN #104 stated this type of transfer should not have occurred and that it was against the home's policy.

During interviews with the EDOC and DOC #100, they both stated that PSW #107 and PSW #109 did not follow safe transferring when transporting resident #001 to their room using the specific equipment and that staff did not follow the licensee's mechanical lift policy. [s. 36.]

Additional Required Actions:

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

Issued on this 11th day of March, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613)
Inspection No. / No de l'inspection :	2020_822613_0008
Log No. / No de registre :	001658-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 10, 2020
Licensee / Titulaire de permis :	F. J. Davey Home 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. Davey Home 733 Third Line East, SAULT STE. MARIE, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Connie Lee

To F. J. Davey Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) (b) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically the licensee must:

A) Ensure all PSW and RPN staff are compliant with the home's policies including: "Falls Prevention and Management Program" (RC-15-01-01), "Mechanical Lifts Procedure" (LP-01-01-02) and "Safe Lifting with Care Program" (LP-01-01-01), as part of the home's adherence to Extendicare's Zero Lift policy and program requirements; and

B) Ensure all staff involved in this incident, including responding Management staff, receive re-education on the home's Falls Prevention and Management Program; review each policy and keep a record of who completed the education, including the date and time and any further corrective action taken.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1., the licensee was required to ensure that the falls prevention and management interdisciplinary program was

developed and implemented to reduce the incidence of falls and risk of injury.

Specifically, staff did not comply with the following licensee's policies:

A) "Falls Prevention and Management Program" (RC-15-01-01) last updated December 2019, which identified that care staff would 1) report any incidents of a resident found on the floor or resident fall immediately to the nurse, 2) ensure that prior to a resident being transferred or assisted to ambulate post-fall, the resident was assessed by a nurse, 3) transfer the resident post-fall, unless, the resident was able to get up on their, and only after the nurse had assessed the resident and approved the transfer.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying resident #001 had a fall and sustained an injury. The CI report revealed that PSW #107 had witnessed the resident fall on a specific date and that resident #001 was transferred to the hospital.

The Inspector reviewed a complaint report that was received by the Director, alleging that PSW #107 had provided improper care to resident #001, following their fall on a specific date.

Inspector #613 viewed the home's video surveillance that identified resident #001 had a fall on a specific date and time. PSW #107 witnessed the resident fall and approached the resident and knelt to their level and then rolled the resident from their right side to a sitting position, on the floor. The PSW moved behind the resident, putting both of their arms under resident #001's armpits and moved the resident closer to them, so that the resident's back was against the front of their body. The PSW proceeded to turn resident #001 to the right with their arms remaining underneath the resident's armpits and manually pulled resident #001 across the floor while the resident was in a seated position, towards the wall. The video surveillance at a specific date and time, revealed PSW #107 had brought a specific equipment to where the resident was in a sitting position with their back propped up against the wall and applied a specific device to the resident by themself. PSW #107, PSW #109, PSW #111 and RPN #105 were now present on the video surveillance and RPN #105 was completing and assessment on resident #001. A couple minutes later, the video surveillance showed PSW #107 and PSW #109 transporting resident #001 down

the hallway using a specific equipment. Resident #001 was in the specific device attached to the specific equipment. RPN #105 and PSW #111 were present during the transfer of resident #001. Later, the video surveillance showed that RN #104 arrived at the unit and ambulated down the hallway, in the direction where resident #001 had been transported by PSW #107 and PSW #109.

The Inspector observed the unit where the resident had fallen and noted that there was a staff assist button located on the wall near where the resident had fallen.

During an interview with PSW #107, they informed the inspector that they had witnessed the resident fall. The PSW stated they did not notify the RPN immediately of the resident's fall; that they did not push the staff assist button and that they could not recall if they had used their portable phone to contact the RPN. PSW #107 stated they had moved resident #001 from a right side lying position on the floor to a sitting position, then moved the resident across the floor, while they were in a sitting position to the wall. The PSW confirmed that they had moved the resident before the RPN arrived at the unit and that they had not received permission to move resident #001.

During an interview with PSW #111, they informed the Inspector that they had heard a noise and a voice calling out, "help me" and arrived at the unit where resident #001 had fallen. The PSW stated they observed PSW #107 positioned behind resident #001, with their arms under the resident's arms and then pulled resident #001 across the floor, while the resident was in a sitting position, and propped the resident with their back against the wall. PSW #111 stated that the resident should not have been moved after falling onto the floor. The PSW further stated that they notified RPN #105 of the resident fall, as PSW #107 had not.

During an interview with RPN #105, they stated that PSW #107 had not notified them of the resident fall immediately. The RPN stated that PSW #107 had not telephoned them nor pushed the staff assist button. RPN #105 further stated they were not sure if PSW #107 had their portable phone with them, when the fall occurred. The RPN stated when they arrived at the unit that resident #001 was in a sitting position with their back against the wall, in the lounge area. The

RPN further stated that they had informed PSW #107 that they were not to move a resident after a fall, until an assessment had been completed by a registered staff.

During an interview RN #104, they stated that PSWs were expected to ensure that a resident was safe following a fall and that they were to immediately notify registered staff of a fall, using the staff assist button or using their portable phones. RN #104 stated PSWs were not to move a resident that had a fall until direction was provided by the registered staff.

During interviews with the EDOC and DOC #100, they stated that PSWs were expected to notify the registered staff immediately with a resident fall. The EDOC and DOC #100, confirmed that PSW #107 should not have moved resident #001 following their fall and not until permission had been provided by the registered staff. They confirmed that PSW #107 did not follow the licensee's falls prevention and management program policy.

B) "Mechanical Lifts Procedure:" (LP-01-01-02) last updated August 2019, which identified 1) two people were required at all times during a resident transfer with a mechanical lift. Two people were required to insert/apply the sling, centre resident with the sling and position the resident arms inside the sling and two staff members were required to remove the sling from underneath the resident. 2) In all situations the resident would be transferred over the shortest distance possible. Under no circumstances would a resident be transported using a mechanical lift (across a room, down a hallway, etc.).

During an interview with PSW #107, they confirmed they had applied the specific device to resident #001 by themself and that they and PSW #109 had transported resident #001 for a specific distance, using a specific equipment. PSW #107 stated that they had received training on safe lifting and transferring and on the use of all types of mechanical lifts. The PSW further stated that they and PSW #109 did not follow the licensee's mechanical lift procedure policy.

During interviews with PSW #111 and RPN #105, they stated that two staff members were required to be present when using the specific equipment, including applying a specific device. Both staff members stated they had received training on safe transferring using a mechanical lift. RPN #105

confirmed that a resident should not be transported using the specific equipment.

During interviews with the EDOC and DOC #100, they both stated that PSW #107 and PSW #109 did not follow safe transferring when transporting resident #001, using the specific equipment and that staff did not follow the licensee's mechanical lift policy. DOC #100 further stated that PSW #107 should not have applied the specific device to resident #001.

C) "Safe Lifting with Care Program (LP-01-01-01)" last updated August 2019, identified that 1) Extendicare was a zero lift facility and that the zero lift program was now integrated with the safe lifting with care program. The zero lift system was designed to eliminate all manual resident lifting and handling through the use of appropriate devices, for the purposes of improving resident quality of life and reducing injuries to staff. 2) All breaches of the Mechanical Lift policy or procedure would result in an investigation and may result in progressive discipline up to and including termination.

A review of the home's internal investigation file revealed a hand written note dated on a specific date, and signed by RN #104 and PSW #107. The note identified that RN #104 had spoken to PSW #107. There was no documentation in the file to identify that an investigation had been done following the staff's breaches of the mechanical lift policy and procedure, following the fall of resident #001 on a specific date.

During interviews with RPN #105, PSW #107 and PSW #111, they all stated that management had not spoken to them regarding the fall of resident #001. They stated they were aware that the home had a zero lift policy and that they could not manually move, handle or lift a resident. All staff interviewed stated they had received training and education on the licensee's falls prevention and management program, mechanical lift procedures and safe lifting with care program.

During an interview with RN #104, they stated that PSW #111 had written a statement of their observations regarding the incident. The RN stated they read the written statement then threw the paper in the garbage.

During an interview with DOC #100, they stated they had been informed of resident #001's fall by RN #104, following the incident and resident #001's transfer to hospital. The DOC further stated that they had viewed the video surveillance involving the incident, the following day. DOC #100 informed the Inspector that they had not investigated the incident and that they had not spoken with any staff member that were involved with the incident.

During an interview the EDOC, they stated that RN #104 should have kept the written statement that had been provided by PSW #111 and that the written statement should have been part of the investigation to this incident and kept in the home's internal file.

During interviews with the Executive Administrator (EADM) and Executive Director of Care (EDOC), they stated they were not aware of the circumstances involved following resident #001's fall or the staff's breaches of the licensee policies until they were informed by Inspector #613, during this inspection. The EADM and EDOC stated they would be investigating this incident further and speaking with all staff involved to prevent recurrence.

The scope of this issue was isolated, and the home had previously unrelated non-compliance; however, the severity of this issue was determined to be a level 3, as there was actual harm and risk to the resident.
(613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2020

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 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 r. 36 of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically the licensee must:

Complete randomized weekly audits, on all shifts, of residents who require mechanical lift transfers, to ensure PSW and RPN staff, on all shifts, are compliant with the home's policies. The home is to keep a record of who completed each audit, the staff name who completed the demonstration, including the date/time of the audit, the name of the resident, details of the resident's transfer care plan in place, any variances found, and corrective action taken.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying resident #001 had a fall and sustained an injury. The CI report revealed that PSW #107 had witnessed the resident fall on a specific date. Resident #001 was transferred to the hospital.

The Inspector reviewed a complaint report that was received by the Director, alleging that PSW #107 had provided improper care to resident #001, following their fall on a specific date.

Refer to WN #1 for further information.

A) During an interview with PSW #111, they stated they had observed PSW #107 positioned behind resident #001, while they were in a sitting position on the floor. The PSW stated that PSW #107 had their arms under the resident's arms and pulled resident #001 across the floor while the resident was in a sitting position and then propped them with their back against the wall. PSW #111 stated that resident #001 should not have been moved after falling onto the floor.

During an interview with PSW #107, they stated that they had received training on safe transferring with care and mechanical lifts. The PSW stated that they had manually moved resident #001, themself, across the floor, so they would be more comfortable and would have something to lean against. PSW #107 verified that they should not have lifted the resident manually across the floor.

During interviews with the Executive Director of Care (EDOC) and Director of Care (DOC) #100, they both confirmed that PSW #107 should not have manually moved resident #001 across the floor. They both confirmed that PSW #107 did not follow the licensee's Safe Lifting with Care Program policy.

B) During an interview with PSW #107, they confirmed they had applied a specific device to resident #001 by themself and that they were attempting to position the resident in the specific device and attach it to the specific equipment before RPN #105 had arrived at the unit. The PSW stated they had received training on safe transferring with care and mechanical lifts. PSW #107 informed the Inspector that a PSW could apply a specific device to a resident themself.

During interviews with RPN #105 and PSW #111, they stated that they had observed PSW #107 applying a specific device on resident #001, by themself and that they were in the process of hooking the resident up to the specific equipment. RPN #105 stated they informed PSW #107 to stop as the resident needed to be assessed by them, prior to moving resident #001. RPN #105 and PSW #111 informed the Inspector that two staff members were required to be present to apply a specific device to a resident and through the entire transfer process. Both staff members stated they had received recent training on safe transferring care program and using mechanical lifts.

During an interview with DOC #100, they stated PSW #107 should not have applied the specific device to resident #001, as the resident should have been assessed by the RPN before any movement of the resident occurred.

C) Inspector #613 observed that resident #001's room was located a far distance from where they had fallen.

During an interview with PSW #107, they confirmed that they had transported resident #001 in the specific equipment from a specific area to the resident's room, with the assistance of PSW #109. The PSW could not recall if RPN #105 had provided direction for this transfer. PSW #107 initially informed the Inspector that they were permitted to transport a resident using a specific equipment, then later stated it was not appropriate.

During an interview with PSW #111, they stated that they were present when PSW #107 and PSW #109 had transported resident #001, using specific equipment, from a specific area to their room.

During an interview with RPN #105, they stated that they were present when PSW #107 and PSW #109 had transported resident #001, using the specific equipment, from a specific area to their room. RPN #105 further stated that they should not have done this and that they did not follow safe transferring when transporting resident #001.

During an interview with RN #104, they stated they were unaware that resident #001 had been transferred to their room using the specific equipment. They further stated that this was too far of a distance to transport resident #001, using the specific equipment. RN #104 stated this type of transfer should not have occurred and that it was against the home's policy.

During interviews with the EDOC and DOC #100, they both stated that PSW #107 and PSW #109 did not follow safe transferring when transporting resident #001 to their room using the specific equipment and that staff did not follow the licensee's mechanical lift policy.

The scope of this issue was isolated, and the home had previously unrelated non-compliance; however, the severity of this issue was determined to be a level

3, as there was actual harm and risk to the resident. (613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 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 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 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 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 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 10th day of March, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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