Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 26, 2023	
Inspection Number: 2023-1544-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: The Corporation of the City of Peterborough and The Corporation of the County of	
Long Term Care Home and City: Fairhaven, Peterborough	
Lead Inspector Carole Ma (741725)	**Inspector Digital Signature**
Additional Inspector(s) Sharon Connell (741721) Patricia Mata (571)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12 - 16, 19 - 23, 2023
The inspection occurred offsite on the following date(s): June 28, 2023

The following intake(s) were inspected:
- Intake related to staff to resident physical abuse
- Intake related to improper care of resident resulting in injury with a significant change in condition
- Complaint intake related to concerns with care, neglect.
- Intake related to a fall resulting in injury with a significant change in condition
- Complaint intake related to concerns with improper care, neglect, nutrition, medication administration
- Complaint intake related to medication administration, consent

An additional 14 intakes completed in this inspection were related to falls.

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The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure that the staff collaborated with the Physician, Nurse Practitioner (NP) or the on-call Physician in the assessment of a resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
A complaint was submitted to the Director alleging improper care.

Over the course of an 11-day period, five separate entries were made in resident #014's progress notes related to a change noted in the resident's appearance and motor skills. Two of the entries indicated the substitute decision maker's (SDM) was concerned and inquired whether a physician had seen the resident.

On the 11th day, the Physician became aware of the resident's change in condition and ordered four tests, a referral to a specialist and blood work.

An RPN could not remember if they had written the concern about the resident's change in the care binder (Physician's communication book) when it was first noted.

By failing to inform the Physician, NP, or the on-call Physician about the change to the resident's

appearance and motor skills, the licensee put the resident at risk for complications due to delayed diagnosis and possible treatment.

Sources: resident's progress notes and interview with RPN #116. [571]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee failed to ensure staff collaborated with the Physician when they were unable to obtain a urine specimen.

Rationale and Summary
A complaint was submitted to the Director alleging improper care.

A review of the clinical record indicated that resident #002 was not behaving as usual. An order was received for urine specimen collection. Three days later the resident worsened. On the fourth day, an order was obtained for the specimen to be collected via a catheter as staff were unable to obtain the specimen. Five days after the resident first presented with symptoms, a specimen was collected.

RPN #141 indicated that it was their practice to inform the Physician if they were unable to collect a urine specimen after two days.

Resident Care Coordinator (RCM) #131 indicated that staff should inform the Physician if they were unable to collect a urine specimen within the first couple of shifts.

By failing to ensure the Physician was informed that staff could not collect a urine specimen until four days after the original order, the staff put resident #002 at risk for a negative outcome.

Sources: resident #002's progress notes and Physician orders, interviews with RPN #141 and RCM #131. [571]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

specified in the plan.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director reporting an unwitnessed fall with injury involving a resident.

A Personal Support Worker (PSW) notified the RPN that they had found the resident on their bathroom floor after they had attempted to self-transfer from the toilet. The resident reported that they had hit their head. The RPN documented that they had performed an assessment, noting that there were injuries which required transfer out for assessment and treatment.

During an observation of the resident's fall prevention equipment, Inspectors found it to be in use for the resident but when the RN demonstrated how the equipment worked it was not functioning. The RN observed that the equipment was not activated, and when this was corrected, the equipment regained its function.

The RN confirmed that it was the responsibility of the PSWs to ensure that the fall prevention equipment was set up correctly and functioning when in use, and they would be reminding them about the instructions for use.

A review of the resident's care plan indicated that the falls prevention equipment was to be applied and functioning when the resident was up.

By failing to ensure that the resident's fall prevention equipment was functioning when in use, as directed in the plan of care, the resident was placed at risk for a fall.

Sources: CIR, observation, Resident's clinical records, staff interview. [741721]

WRITTEN NOTIFICATION: CONSENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7

The licensee has failed to ensure that it was authorized to provide care or services to a resident without the resident's consent.

Section 2 of FLTCA defines "substitute decision-maker" as a person who is authorized under the Health Care Consent Act, 1996 or the Substitute Decisions Act, 1992 to give or refuse consent or make a decision, on behalf of another person.

Rationale and Summary
A complaint was made to the Director on a specific date, by a resident's SDM related to the resident being administered an immediate (STAT) medication without consent, on a specific date.

The resident's clinical records, an incident investigation report completed by a PSW, and a written witness statement provided by a Behavioural Support Ontario (BSO) PSW, indicated the resident was upset and kicked the PSW in the back of the knee. The resident was removed from the hallway and vicinity of other residents by an RPN, and given support.

During this incident, the resident's behaviour and refusals of interventions were documented. They did speak with the SDM, and the RPN indicated this conversation had no impact on the resident.

In an interview, the RN identified the situation as an emergency due to the risk to resident safety, and that co-residents could react to the situation. They, however, did not document at the time that the resident and co-residents were at risk of harm. The RN documented they obtained a new order from the on-call physician for a STAT medication and administered the medication to the resident at a specified time.

The PSW indicated they overheard the RPN mention the medication name when speaking with the SDM on the phone, but was unable to hear if consent for its use was provided. The resident's clinical records showed the RPN documented they had spoken with the SDM on the use of the STAT medication but also did not include if consent was provided. During an interview, the RPN indicated they could not recall any further details and that if the RN received the new medication order, then they should be getting consent prior to administering it.

On a specific date, the RN confirmed that as part of the home's process for obtaining a STAT medication order, the family would need to give their approval before its administration. An RCM indicated that the situation was escalating but acknowledged the home's policy was to attain consent before administering a new medication, and that in this specific incident, the policy was not followed.

In failing to obtain consent from the SDM before administering a STAT medication, the home exposed the resident to potential medication misuse and side effects, and an erosion of their rights and trust.

Sources: Resident's clinical records, Incident Investigation form, written statement by a BSO PSW, interviews with the PSW, RPN, RN and RCM. [741725]

WRITTEN NOTIFICATION: PROTECTION FROM CERTAIN RESTRAINING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 4.

The licensee has failed to ensure that a resident was not restrained by the administration of a drug to control the resident, other than under the common law duty referred to in section 39 of the Act.

Section 39 of the Act states nothing in this Act affects the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.

Rationale and Summary
A complaint was made to the Director on a specific date, by a resident's SDM related to the resident being administered an immediate (STAT) medication without consent.

The resident's clinical records, an incident investigation report completed by a PSW, and a written witness statement provided by a Behavioural Support Ontario (BSO) PSW, indicated the resident was upset and kicked the PSW in the back of the knee. The resident was removed from the hallway and vicinity of other residents by an RPN, and given support.

During this incident, the resident's behaviour and refusals of interventions were documented. They did speak with the SDM, and the RPN indicated this conversation had no impact on the resident.

In an interview, the RN identified the situation as an emergency due to the risk to resident safety, and that co-residents could react to the situation. They, however, did not document at the time that the resident and co-residents were at risk of harm. The RN documented they obtained a new order from the on-call physician for a STAT medication and administered the medication to the resident at a specified time.

In their written statement, the BSO PSW indicated they saw the resident directed to a safe and quiet area with two RNs who spoke with and reassured the resident before, during and after the medication administration. The BSO PSW observed the resident holding onto a tea tumbler with both hands during this time.

In failing to meet the threshold of common law duty, and using a medication as a chemical restraint, the home exposed the resident to medication misuse and potential side effects, and an erosion of their rights and trust.

Sources: Resident's clinical records, Incident Investigation form, written statement by BSO PSW, interviews with the PSW, RPN and RN. [741725]

WRITTEN NOTIFICATION: PROTECTION FROM RESTRAINING AND CONFINING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.

The licensee failed to ensure that no resident of the home was confined, due to the use of a hook and eye lock on the outer side of a resident's bathroom door.

Rationale and Summary
A hook and eye lock was observed on the outside of a resident's bathroom door, which if latched would prevent the occupant of the bathroom from exiting. There was no secondary exit from this bathroom.

A PSW stated that the home area where the resident resided had hook and eye locks on two residents' bathrooms and these were used for one of two reasons: to prevent a resident who requires assistance from transferring on their own, or to prevent residents with dementia from wondering through a shared bathroom into an adjoining bedroom.

The Falls Lead indicated that hook and eye locks on resident bathroom doors were used as needed and normally installed to prevent aggressive, wandering residents access to a neighbouring resident's room through a shared bathroom, but this was not the situation in this resident's room. The Falls Lead submitted a work order during the inspection to remove the hook that was on the resident's bathroom door, writing that the hook and eye lock was not an appropriate intervention for fall prevention.

By failing to ensure that no resident of the home is confined, residents were placed at risk of harm related to inability to release the lock attached to the outer side of the resident bathroom door.

Sources: Observation, staff interviews. [741721]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when unsupervised by staff.

Rationale and Summary
1) Observations during the inspection identified two resident supply room doors in a resident home area that were left unattended and propped open by linen carts. A PSW demonstrated that the door could be locked when closed and used their key to open it.

Two PSWs confirmed that they had left the linen carts propping the supply room doors open. One of the PSWs shared that it was a rule of the home to keep it locked.

By failing to ensure that all doors leading to non-residential areas were kept closed and locked when unsupervised, residents were placed at risk of being trapped in a non-resident area.

Sources: Observations, staff interviews. [741721]

2) On a specific date, the door to a specific resident storage room was found to be locked but partially opened with no staff inside. An RPN confirmed that the issue posed a risk because there were residents on the unit who do try to open doors and that if a resident did enter the room, they would not necessarily be able to come out. There was no resident communication system inside the room, so a resident could remain inside for an unknown period of time. The Environmental Services Manager (ESM) was informed of the issue.

Additional observations of resident storage room doors being left open were made. On a later date, the same door was found to be left open. On two different dates, a door on two separate resident home areas (RHAs) were found to propped open with a clean linen cart.

In failing to ensure resident storage room doors were kept closed and locked in multiple RHAs when not supervised, residents were at risk of entering non-residential areas and potentially being unable to exit.

Sources: Observations, interviews with the RPN, ESM. [741725]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee failed to ensure that a resident had a post-fall assessment completed, using clinically appropriate assessment instruments, specifically designed for falls which included a head injury routine(HIR).

Rationale and Summary
A CIR was submitted to the Director reporting an unwitnessed fall with injury involving a resident.

A PSW notified the RPN that they had found the resident on their bathroom floor, after attempting to self-transfer. The resident reported that they had hit their head. The RPN documented that they had performed an assessment of the residents' injuries and started an HIR prior to transfer.

An RN confirmed in an interview that RPNs were responsible for completing a paper copy of the HIR for unwitnessed falls and documenting the start and stop dates in the progress notes. The RN confirmed that when a resident returned from a transfer within 72 hours (hrs) of their fall, the HIR assessments should then be re-initiated.

The Falls Lead indicated that after a resident falls, the expectation of the home was to complete a post falls assessment in Point Click Care (PCC) under Risk Management, and if an HIR was required, it would be completed on paper for 72 hrs. They confirmed that the Post Fall Assessment for the resident, for the specified date, was incomplete.

Review of the clinical records for the resident revealed that the post falls assessment under Risk Management in PCC was incomplete and there was no progress note indicating the completion of the HIR, 72 hrs post fall.

The Director of Care (DOC) confirmed that the missing paper copy of the neurological observation record for the resident's specified fall did not exist, as the nurse had instead documented their head injury assessments in the electronic progress notes. When asked if the progress notes contained all the information required on the neurological observation record, the DOC confirmed it was not complete as there were no pupil checks.

The home's HIR Policy directed registered staff to document all assessment and monitoring on the 'Neurological Observation Record' at set intervals for 72 hrs.

By failing to ensure that the resident had a post-fall assessment using a clinically appropriate assessment instrument, specifically designed for falls, including head injuries, the licensee placed the resident at risk for a potential delay in recognition of medical complications.

Sources: CIR, Resident's clinical records, Head Injury Routine policy, staff and DOC interviews. [741721]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control (IPAC) was implemented.

1) The IPAC Standard for Long-Term Care Homes (IPAC Standard), dated April 2022, section 6.1 states the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care (MLTC), which may be in place.

Rationale and Summary
On a specific date, four residents remained on droplet contact precautions, and one resident remained on contact precautions, as indicated by their clinical records in PCC and confirmed by the IPAC lead. On the door of their rooms hung a PPE caddy.

The IPAC lead confirmed that staff on shift were responsible for stocking the caddies. Each caddy should have clean gowns, surgical masks, gloves, low level disinfectant wipes, and a small supply of garbage bags.

One caddy did not contain any gloves and three of them did not contain surgical masks. One caddy had surgical masks, however, they were removed from their packaging and left exposed in the caddy pocket, which the IPAC lead identified as unacceptable. Only one caddy contained a cannister of low-level disinfectant wipes used to clean shared equipment such as transfer lifts and goggles.

In failing to provide an adequate supply of PPE for staff providing care to residents on additional precautions, the home placed residents at potential risk for transmission of infectious organisms.

Sources: Review of residents' clinical records, observations, interview with IPAC lead. [741725]

2) The IPAC Standard, section 9.1 Routine Practices (b) states the licensee at minimum shall include Hand Hygiene (HH), including, but not limited to, the four moments of hand hygiene (before initial

resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
On a specific date, in a dining room (DR), a student was observed holding a resident's hand and then unwrapping a straw for another resident. They then returned to holding the first resident's hand. The student acknowledged they did not perform HH between resident contact.

During the same meal service, a PSW was observed serving food to multiple residents across four table groupings. They were observed touching residents on the shoulder, adjusting wheelchairs, moving a facecloth that was on a table, scratching their hair and adjusting their own mask. They did not perform HH at any point during this sequence of events and indicated that it would take a lot of time since the DR only had wall-mounted alcohol-based hand rub (ABHR) dispensers. They suggested being supplied with a bottle of ABHR on their cart.

On a later date, in another RHA, a Dietary Aide (DA) was observed serving snacks and not performing HH between resident contacts. They were observed giving a resident a cup of water and a cookie, and then observed handing a cookie with their bare hands to another resident. The DA indicated that they perform HH in between rooms, after touching a resident or if they touch something dirty.

The home's HH policy confirmed that staff must clean their hands at a minimum, according to the four moments and specifically mentioned before initial resident contact or contact with their environment, and after resident contact or contact with their environment.

In failing to ensure staff met the expectations for conducting HH during meal and snack service, residents were put at risk for transmission of infectious organisms.

Sources: Observations, interviews with the student, PSW, DA, hand hygiene policy. [741725]

3) The IPAC Standard, section 9.1 Additional Precautions (e) states the licensee shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary
On a specific date, three residents remained on droplet contact precautions as indicated by their clinical records in PCC and confirmed by the IPAC lead. The signage posted by their doors, however, indicated they were on only droplet precautions.

The IPAC lead confirmed that additional precautions signage should match the documented type of

transmission and that the residents should have had a droplet contact sign posted by their doors.

The home's outbreak responsibilities policy indicated the registered nurse must ensure symptomatic residents have appropriate signage on their door.

In failing to post the correct signage by the door of residents who were on droplet contact precautions, staff and visitors entering the room were not made aware of the appropriate precautions to take in order to avoid transmission of infectious organisms, and may potentially have placed themselves and residents at risk for infection.

Sources: Review of residents' clinical records, observations, interview with IPAC lead, outbreak responsibilities policy. [741725]

4) The IPAC Standard, section 9.1 Additional Precautions (f) states at a minimum, Additional Precautions shall include additional PPE requirements including appropriate selection application, removal and disposal.

Rationale and Summary
On a specific date, a PSW was observed wearing a surgical mask and exiting a resident's room, who was on droplet contact precautions. A physiotherapist and nurse documented the resident was unable to follow instructions and was up and moving freely about their room.

The PSW confirmed they were providing 1:1 monitoring for the resident, and was also involved in providing care that included activities of daily living (ADLs). They confirmed they should be wearing a gown, gloves and face shield, which were already in the room, and indicated they had exited the room to put on a gown. They acknowledged they should be wearing appropriate PPE before entering the room.

The IPAC lead confirmed that staff were required to conduct a personal care risk assessment (PCRA) based in part on tasks to be conducted and distance kept from the resident. The home's droplet/droplet contact precautions policy indicated a PCRA included the resident's level of cognition and ability to follow instructions, in determining the appropriate PPE for each resident interaction.

In failing to wear appropriate PPE, the PSW was at risk of rhinovirus exposure and transmission of the infectious organism to other residents.

Sources: Resident's clinical records, observations, interviews with the PSW and IPAC lead, droplet/droplet contact precautions policy. [741725]

5) The IPAC Standard, section 10.4 (h) states the license will ensure residents receive support to perform HH prior to receiving meals and snacks.

Rationale and Summary
On a specific date, residents were observed entering a DR for lunch time meal service but were not supported in conducting HH prior to receiving their meal.

While seated in the DR, a resident confirmed that staff did not ask or check if HH had been conducted by residents and did not offer residents to help clean their hands. A PSW indicated that staff clean residents' hands after meals, but not usually before because they get angry and don't like "stuff" on their hands.

On another date, in a different RHA, a DA was observed serving snacks to two residents who were not supported in conducting HH and one resident had received a cookie into their bare hands. When asked if residents were supported in conducting HH before receiving a snack, the DA indicated that it was not part of their job routine.

The IPAC lead confirmed residents were at potential risk of infection if they were not being supported in performing HH at the start of meal service.

Sources: Observations, interviews with the PSW, DA, and IPAC lead. [741725]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
A CIR was submitted to the Director on a specific date.

The IPAC lead acknowledged the report was submitted late.

There was no risk to residents with this late reporting.

Sources: CIR, interview with IPAC lead. [741725]

COMPLIANCE ORDER CO #001 TRANSFERRING AND POSITIONING TECHNIQUES

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 36

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee is ordered to comply with the following:

1. Identify a designated Lead and a back up to oversee the Safe Lift and Transferring Program including training.
2. Safe Lift and Transfer education, including hands-on training for every make and model of mechanical lift and sling, is to be completed for every new direct care staff, every new agency nursing staff and annually to all nursing staff as part of the Falls Program. Keep a written record of the training provided and make immediately available to the inspector upon request.
3. Ensure a checklist demonstrating all the steps involved in performing a safe lift and transfer is completed and signed by the trainee and trainer. Records are to be kept and made immediately available to the inspector upon request.
4. Reassess every resident that is transferred using a mechanical lift to ensure the sling is the proper size as per the manufacturer’s instruction. Keep records of the assessments including the specific sizing charts used. Ensure there is clear direction to staff regarding the manufacturer and size of the sling and mechanical lift that they are to use to transfer each resident.
5. Ensure all slings and lifts in use are checked and/or inspected to ensure they are functioning and safe, daily before each use, and as per manufacturers' instruction. Records are to be kept and made available to the inspector immediately upon request.
6. Develop a written process to ensure that when a resident is assessed or reassessed and a change is made to a sling or lift, there is clear documentation explaining why there was a change and how this change is to be communicated to direct care staff. Educate direct care staff on this process and keep a documented record of the education which is to be made available to the inspector immediately upon request.

Grounds
The licensee failed to ensure staff used safe transferring techniques when transferring a resident from their bed to a chair.

A CIR was submitted to the Director related to resident #013 sustaining injuries from a fall. PSWs #132 and #133 where transferring resident #013 from their bed to their chair using a mechanical lift and an assigned sling. The transfer resulted in injury to the resident.

The licensee's policy in place at the time of the incident advised staff to most importantly, ensure the sling attachment loops are fully secured on the carry bar before and during the lift.

PSW #132 and #133 indicated that they had used the mechanical lift as they had been trained and had made sure the loops of the straps on the sling were engaged. PSW #133 believed that the sling the staff were using at the time was not the correct size and this contributed to the incident.

The licensee's process for determining sling sizes for use with the mechanical lifts involved the RN's using a chart posted in their office. The size of the sling used was determined by the resident's weight and height regardless of the manufacturer of the sling or mechanical lift. In addition to the chart the RN's used, there were at least three other sources of sizing charts found, including printed on some slings, posted in a storage room on a resident home area and in the lift and sling manual. Of the four separate sources, only one chart indicated that the resident should use the sling that was assigned to the resident at the time of the incident.

PSW #142 indicated that they knew what size sling to use for resident transfers because it was in the Kardex and there was a visual cue.

A review of the resident's care plan, in place at the time of the incident directed staff to lift the resident with a mechanical lift, using a specific sling size. The care plan dated after the incident directed staff to transfer the resident with mechanical lift using a specific size if using a Tollos sling and a different size if using a Handicare sling.

A review of a sample of the invoices for slings at that time showed that the licensee ordered Tollos and Handicare transfer slings.

RCM #143 indicated at the time of the incident, PSW #132 or another staff member did safe lift and transfer training. At the time of the inspection, no one was overseeing the safe lift and transferring program.

The DOC was unable to provide safe lift and transferring training records for the time that the incident occurred.

By the licensee failing to ensure safe lift and transfer techniques where used, the resident sustained serious injuries.

Sources: CIR; policies; licensee investigation notes; interviews with PSW #132, 133 and 142, RN #134, RCM #143 and emails from the DOC; observations of two different Tollos lifts and multiple Tollos and

Handicare slings. [571]

This order must be complied with by August 25, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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