Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 11, 2016	2015_189120_0092	031300-15	Critical Incident System

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

BERNADETTE SUSNIK (120), LISA VINK (168)

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): November 16 and December 2, 2015

Critical Incident #2776-0000029-15

During the course of the inspection, the inspector(s) spoke with the Director of Nursing(DON), Clinical Co-ordinator, Staff Development Nurse (Staff Educator), Registered Staff, Personal Support Workers (PSW)and Environmental Services Supervisor.

During the course of the inspection, the inspectors reviewed the resident's plan of care, progress notes, pain and falls risk assessments, post fall assessments, pain, falls and transfer policies and procedures, lift and sling inspection audits, observed the condition of slings, reviewed manufacturer's lift and sling instructions, staff orientation records in the use of slings and lifts and staff training and education records in pain management and falls prevention management.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain
Safe and Secure Home
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following, subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

Subsection 76 (7) paragraph 6 of the Act identified that all staff who provided direct care to residents received, as a condition of continued contact with residents, training in the areas provided for in the regulations.

Subsection 221 (1) paragraphs (1) and (4) of the Regulation identified that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were areas in which training would be provided to all staff who provided direct care to residents: falls prevention and management and pain management.

A. Interview with the staff development nurse identified that training was not provided to all direct care staff in 2014 for pain management as the home did not offer in house pain education in 2014. She confirmed that in December 2015, a number of in-services were scheduled for pain management for direct care staff.

B. Interview with the staff development nurse confirmed that training was not provided to all direct care staff in 2015 for falls prevention and management. According to the in-service sign-in sheets (attendance record) the home offered a total of 4 training sessions on falls management in 2015, with a total of 63 staff attending. The DON identified that the home had approximately 150 direct care nursing staff. The staff development nurse confirmed that no additional training for falls prevention and management was scheduled for 2015 and that not all staff had received the required training.
[s. 221(1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that in respect to each of the organized programs required, including the programs for falls prevention and management and pain management that there was a written description for each of the programs that included goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, and that the programs be evaluated and updated at least annually and that a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A. The home's pain management program included a policy titled "Pain Assessment, 05-01-04A", dated January 2015. The policy identified that the home had two pain assessment tools available for use, one for cognitively alert residents and a second for

cognitively impaired or non-communicative residents.

Discussion with the DON, clinical co-ordinator and registered staff member #203 each confirmed that the home had only one pain assessment in place, an electronic tool which was being used for all residents; however, staff also utilized a pain rating scale from 1-10 for those residents who could respond to the questionnaires. According to the DON the decision was made to use only one tool as residents had a hard time answering the questions contained in the first pain assessment. The home evaluated their pain policy when they made changes to the available assessment tools; however, there was no formalized record available related to this evaluation and the policy was not revised to reflect the changes, as per the DON and clinical coordinator.

Discussion with the clinical coordinator confirmed that the home had goals and objectives for the pain management program; however these were informal and not consistently recorded or evaluated.

B. The home's falls prevention and management program was requested and reviewed which included a document titled "Resident Care - Resident Falls, 09-02-01", dated December 2014, which identified factors to be considered when investigating falls; a generic Incident Report and a one page policy titled "Falls", dated January 2015, which identified some of the steps for staff to take when a resident sustained a fall. The home also utilized a Falls Risk tool which was completed electronically.

Interview with the DON confirmed that these documents made up the falls prevention and management program and confirmed that the program needed to be revised as it did not meet all of the necessary requirements, including but not limited to a clinically appropriate post fall assessment instrument. It was confirmed, by the DON and by registered staff member #208, who was the secretary of the Falls Committee, that the home had a committee, which met on a monthly basis and that goals and objectives were discussed on a routine basis at this meeting; however, that they were informal and not consistently recorded. [s. 30(1)]

2. The licensee did not ensure that the lift equipment, specifically the sling used by the staff was appropriate for the resident based on the resident's condition.

During the morning of the incident which occurred in late 2015, resident #101 did not co-operate with staff to be transferred manually from their bed to a wheelchair and was subsequently transferred manually by 4 personal support workers. According to staff

member #200, the resident was very lethargic and did not assist with the transfer as they normally did in the days prior to the incident. Other staff members who were interviewed reported that the resident's condition had changed or deteriorated since September 2015 and depending on the day, would require a mechanical lift called a "sit-to-stand" lift due to her lethargy. Progress notes made 6 days prior to the incident also indicated that the resident was weak.

During the evening of the incident, resident #101 required a transfer back to bed from their wheelchair. According to staff member #200 and registered staff member #203, the resident was resistive, non-co-operative and quite lethargic and not able to assist with the manual transfer process and staff member #200 decided to use a mechanical floor lift with the assistance of staff member #201. As the resident had not been assessed for the use of a mechanical floor lift and had not been assigned a particular sling type or sling size, the staff members borrowed a sling from another resident which was slightly heavier than resident #101. The sling chosen was a large sling called a "loop toilet sling", which according to the manufacturer and their instructions for use titled "Passive Clip Slings" dated November 2011 (provided by the Clinical Co-ordinator) and "Sling User Guide", dated March 2005 was designed for use during "toilet related situations" and "not for lifting and transport". The directions for use cautioned that "if the resident can not hold on tightly, they will slide out" and that "careful patient assessment was necessary before the sling was used". The sling was also a large sling designed for someone between 70-120 kg, which was several kilograms above the resident's weight. The sling was observed to be designed without any support for the buttocks and had padded leg straps, 2 head support strap buckles, a back and neck support and padded sides which were required to be placed just under the resident's arm pits with the arms on the outside of the sling. The resident would be required to hold on tightly during the lift process as the majority of their weight would be held up by the underside of their arms and was dependent on their upper body strength and compliance to hold on to the sides of the sling. Due to the resident's condition as described above by the staff members, the manufacturer's instructions suggested that a general sling be used, which was designed to support the entire body and did not require the assistance of the resident in any way. General slings of various sizes were observed to have been available in the home at the time of inspection and according to staff, were available on the date of the incident. The home's Physiotherapist reported that the resident was referred to him for an assessment by registered staff one day prior to the incident to determine suitability for a mechanical lift for future transfers. When he went to see the resident one day after the incident, the resident had already fallen and was in pain and did not want to be assessed, however a note was made that the resident was to receive future transfers using a mechanical floor

lift and appropriate sling.

As the resident was being transferred with the toileting sling, the resident slid out of the sling head first during the transfer process. According to staff member #200, she believed that a noise from the lift motor startled the resident which caused them to retract their arms from the outside of the sling to the inside, causing the weight to be displaced and the sling to tip backwards. [s. 30(1)2.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee did not ensure that all staff received training in the safe and correct use of equipment including mechanical lifts and associated accessories before performing their responsibilities.

According to the Staff Development Nurse, the registered and non-registered staff received written instructions on proper body mechanics and ergonomics on how to use mechanical lifts during their orientation. The staff member was then paired up with an existing staff member who was responsible for showing them how to use the mechanical lifts and associated slings. At no point were staff assessed to determine if they were trained to use the lift and slings safely and correctly by a manager or person with some expertise in the use of the lifts and slings. According to staff interviews, many who have been employed for more than 10 years and were appointed to train new staff members, had not received training themselves since they first started. During the inspection, no lift and sling user manuals or guide books were readily available to staff for reference with the exception of a guide book titled "Passive Clip Slings" dated November 2011. The guide book was in the possession of the Clinical Co-ordinator who was tasked with providing residents with the appropriate sling size. Other reference guides for inspecting the slings were found post inspection with maintenance staff. [s. 218. 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home's procedure titled "Neurological Signs: Head Injury Routine, 08-01-27", dated December 2014, identified that assessments be implemented for all suspected or confirmed head injuries. The routine included specified assessments be completed and recorded every 15 minutes for 2 hours, then if stable, every 30 minutes for 2 hours, then every hour for 4 hours, then if stable, every 4 hours for 16 hours and then if stable every 8 hours for 72 hours.

Resident #101 was involved in an incident in late 2015 whereby the initial progress note identified that their mid back and head were involved in the incident. Registered staff #203, who worked at the time of the incident, initiated the Head Injury Routine, as confirmed during staff interview and record review on December 2, 2015. A review of the Neurological Assessment Record, where the Head Injury Routine was to be recorded, identified that the resident was asleep for 4 of the every 30 minute checks and that no assessment was recorded on these occasions. Interview with registered staff member #206, who was working during the 4 identified checks, verified that she did not complete the assessments as the resident was sleeping comfortably and she did not want to disturb their sleep. Interview with the DON confirmed that the Head Injury Routine was not completed as required and confirmed the expectation that the assessment be completed even if the resident was sleeping.

B. The home's policy titled "Pain Assessment 05-01-04A", dated January 2015, identified that residents be screened for pain routinely and as needed when they had a complaint of pain and that a nurse would use their judgment "if the behaviours indicated that pain may be experienced" and that a nurse would "complete a re-assessment of pain quarterly and if the pain increased or changed significantly, would complete PRN (Pro re Nata - as needed) until pain is reduced to < 3" (less than 3).

The home provided a copy of their Nursing Practice Council Meeting Minutes dated March 2, 2015, which identified that pain assessments be completed after a fall or other incident and if the score was greater than 3, an intervention be instituted and an additional assessment completed within an hour for effectiveness of the intervention.

Resident #101 had a long-standing issue with pain for which there was a plan of care in place, which was recently revised due to a change in care needs. The resident was involved in an incident in late 2015, during the evening shift, for which they had a pain

assessment completed and rated their pain at a level of 6, a moderate level of pain. Interview with registered staff member #203, who completed the assessment, confirmed that due to the incident the resident may have experienced additional pain; however, the decision was made not to give additional analgesic medication due to the drowsy state of the resident and rather decided to monitor them for changes in condition. Following the incident the resident was placed into bed and settled to sleep following a visit from family. The resident had no other unusual signs or symptoms of pain according to staff #203 for the remainder of the shift or on the following shift according to staff interviews of registered staff member #206 and PSW #207. The resident did not have a formalized reassessment of their pain completed despite the fact that the incident could have resulted in pain. The decision was made not to provide additional analgesic medication despite a pain score level of 6. The home's policy was not complied with and was confirmed by the DON and registered staff member #203 and staff member #206. [s. 8(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented to ensure that all equipment was kept in good repair.

Mechanical lifts and associated slings were noted to be in use in the home at the time of inspection. The slings in particular were observed to be worn in appearance (overly flexible, faded), with worn out tags that were unidentifiable as to size and year of manufacture. One sling in particular was pulled from room 104 that had stitching that was loose. According to the manufacturer's "Sling User Guide" dated March 2005, any loose stitching, worn out tags or fraying needed to be withdrawn from use. According to the manufacturer's consultant, depending on the number of times a sling was laundered and used, the life span of a sling is approximately 4 years. The tags on the 10 slings reviewed were so worn out, no information as to their age could be verified. The Clinical Co-ordinator did not have any records as to when the slings were purchased or put into circulation, but recalled that they had been in the home for at least 7 years.

A review of the sling inspection process, a component of the home's preventive maintenance process to ensure the slings remained in good condition was reviewed with the Clinical Co-ordinator. According to the sheets completed by various PSWs, the slings were checked for condition on a daily basis along with the condition of the lift before each use. The check list did not specify which sling was being checked and over 10 slings were noted to be in circulation on one wing on the first floor. No reference guide was available to determine what exactly the PSWs were to look for (sling or lift) and what directions to follow when certain conditions were identified. No procedure was available for review of the lift and sling inspection process. [s. 90(2)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that all equipment is kept in good repair (excluding the residents' personal aids or equipment), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #101 was involved in an incident during a transfer in late 2015. At the time of the transfer, 2 staff members used a mechanical lift with a toileting sling. A review of the logo sheet which would have been in place at the time of the incident for staff reference and was dated October 9, 2015, (which was manually updated on November 2, 2015) identified that a one person assist was required for transfers (without a mechanical lift). A review of the electronic plan of care, which would have been in place at the time of the incident, identified that staff were to provide two person extensive physical assistance (without a mechanical lift). Interview with the Director of Nursing (DON) reported that it was the home's expectation that staff work in pairs and that two staff be present for all transfers; however, when shown the logo sheet, it identified that the resident required a one person transfer (without mechanical lift). The plan of care did not give clear direction regarding the level of assistance for transfers. [s. 6(1)(c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was assessed post fall using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #101 was involved in an incident in late 2015, which was considered and documented as a fall. Following this incident the resident was assessed by registered staff. The staff documented their assessment of the resident in the progress notes and on the home's Incident Report, which was confirmed during a record review and interview with registered staff member #203. The clinical record for the resident did not include a clinically appropriate assessment instrument, specifically designed for falls. Interview with the DON confirmed that the home did not have a clinically appropriate assessment instrument that was specifically designed for falls, only an Incident Report which was utilized for a variety of incidents and as part of their quality program. [s. 49(2)]

Issued on this 11th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120), LISA VINK (168)
Inspection No. / No de l'inspection :	2015_189120_0092
Log No. / Registre no:	031300-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 11, 2016
Licensee / Titulaire de permis :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rosemary Okimi

To HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall provide training, to all direct care staff, in the areas of falls prevention and management and pain management including pain recognition of specific and non-specific signs of pain, by June 1, 2016.

This training shall include, but not be limited to all changes to the newly revised programs, including the goals and objectives of the programs, relevant policies, procedures, and protocols of the programs, and information on the safe and required use of the available equipment, supplies, devices or aids of each program.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following, subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

Subsection 76 (7) paragraph 6 of the Act identified that all staff who provided direct care to residents received, as a condition of continued contact with residents, training in the areas provided for in the regulations.

Subsection 221 (1) paragraphs (1) and (4) of the Regulation identified that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were areas in which training would be provided to all staff who provided direct care to residents: falls prevention and management and pain management.

A. Interview with the staff development nurse identified that training was not provided to all direct care staff in 2014 for pain management as the home did not offer in house pain education in 2014. She confirmed that in December 2015, a number of in-services were scheduled for pain management for direct care staff.

B. Interview with the staff development nurse confirmed that training was not provided to all direct care staff in 2015 for falls prevention and management. According to the in-service sign-in sheets (attendance record) the home offered a total of 4 training sessions on falls management in 2015, with a total of 63 staff attending. The DON identified that the home had approximately 150 direct care nursing staff. The staff development nurse confirmed that no additional training for falls prevention and management was scheduled for 2015 and that not all staff had received the required training. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall review and revise their required programs related to falls prevention and management and pain management.

This revision shall ensure that each of the programs include all of the legislative requirements as outlined in the Ontario Regulation 79/10 and the Long Term Care Home Act, 2007, specifically:

1. a written description for each program which includes the programs goals and objectives, which are to be formally evaluated on a yearly basis

2. relevant policies, procedures, assessment tools and protocols, including

methods to reduce risk and monitor outcomes, and protocols for the referral of residents to specialized resources where required.

The falls management program must include, at a minimum:
i. strategies to reduce or mitigate falls, including the monitoring of residents and review of drug regimes,
ii. the use of restorative care approaches,
iii. the use and availability of appropriate equipment, supplies, devices and assistive aids based on the assessed needs of residents,
iv. a post-fall assessment instrument, which is clinically appropriate and specifically designed for falls and includes directions for how and when to use,

The pain management program must include, at a minimum:
i. communication and assessment strategies for residents who are unable to communicate their pain due to cognitive impairment or other communication challenges, including language barriers,
ii. strategies to manage pain including non-pharmacologic interventions, equipment, supplies, devices and assistive aids,
iii. comfort care measures,
iv. the monitoring of residents' responses to, and the effectiveness of, pain management strategies,
v. a system to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for pain.

3. that the programs are evaluated and updated at least annually.

4. that a written record relating to each evaluation is maintained which includes the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date that those changes were implemented.

Grounds / Motifs :

1. The licensee failed to ensure that in respect to each of the organized programs required, including the programs for falls prevention and management and pain management that there was a written description for each of the programs that included goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where

required, and that the programs be evaluated and updated at least annually and that a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A. The home's pain management program included a policy titled "Pain Assessment, 05-01-04A", dated January 2015. The policy identified that the home had two pain assessment tools available for use, one for cognitively alert residents and a second for cognitively impaired or non-communicative residents.

Discussion with the DON, clinical co-ordinator and registered staff member #203 each confirmed that the home had only one pain assessment in place, an electronic tool which was being used for all residents; however, staff also utilized a pain rating scale from 1-10 for those residents who could respond to the questionnaires. According to the DON the decision was made to use only one tool as residents had a hard time answering the questions contained in the first pain assessment. The home evaluated their pain policy when they made changes to the available assessment tools; however, there was no formalized record available related to this evaluation and the policy was not revised to reflect the changes, as per the DON and clinical coordinator.

Discussion with the clinical coordinator confirmed that the home had goals and objectives for the pain management program; however these were informal and not consistently recorded or evaluated.

B. The home's falls prevention and management program was requested and reviewed which included a document titled "Resident Care - Resident Falls, 09-02-01", dated December 2014, which identified factors to be considered when investigating falls; a generic Incident Report and a one page policy titled "Falls", dated January 2015, which identified some of the steps for staff to take when a resident sustained a fall. The home also utilized a Falls Risk tool which was completed electronically.

Interview with the DON confirmed that these documents made up the falls prevention and management program and confirmed that the program needed to be revised as it did not meet all of the necessary requirements, including but not limited to a clinically appropriate post fall assessment instrument. It was confirmed, by the DON and by registered staff member #208, who was the

secretary of the Falls Committee, that the home had a committee, which met on a monthly basis and that goals and objectives were discussed on a routine basis at this meeting; however, that they were informal and not consistently recorded. (168)

2. The licensee did not ensure that the lift equipment, specifically the sling used by the staff was appropriate for the resident based on the resident's condition.

During the morning of the incident which occurred in late 2015, resident #101 did not co-operate with staff to be transferred manually from their bed to a wheelchair and was subsequently transferred manually by 4 personal support workers. According to staff member #200, the resident was very lethargic and did not assist with the transfer as they normally did in the days prior to the incident. Other staff members who were interviewed reported that the resident's condition had changed or deteriorated since September 2015 and depending on the day, would require a mechanical lift called a "sit-to-stand" lift due to her lethargy. Progress notes made 6 days prior to the incident also indicated that the resident was weak.

During the evening of the incident, resident #101 required a transfer back to bed from their wheelchair. According to staff member #200 and registered staff member #203, the resident was resistive, non-co-operative and quite lethargic and not able to assist with the manual transfer process and staff member #200 decided to use a mechanical floor lift with the assistance of staff member #201. As the resident had not been assessed for the use of a mechanical floor lift and had not been assigned a particular sling type or sling size, the staff members borrowed a sling from another resident which was slightly heavier than resident #101. The sling chosen was a large sling called a "loop toilet sling", which according to the manufacturer and their instructions for use titled "Passive Clip Slings" dated November 2011 (provided by the Clinical Co-ordinator) and "Sling User Guide", dated March 2005 was designed for use during "toilet related situations" and "not for lifting and transport". The directions for use cautioned that "if the resident can not hold on tightly, they will slide out" and that "careful patient assessment was necessary before the sling was used". The sling was also a large sling designed for someone between 70-120 kg, which was several kilograms above the resident's weight. The sling was observed to be designed without any support for the buttocks and had padded leg straps, 2 head support strap buckles, a back and neck support and padded sides which were required to be placed just under the resident's arm pits with the arms on the outside of

the sling. The resident would be required to hold on tightly during the lift process as the majority of their weight would be held up by the underside of their arms and was dependent on their upper body strength and compliance to hold on to the sides of the sling. Due to the resident's condition as described above by the staff members, the manufacturer's instructions suggested that a general sling be used, which was designed to support the entire body and did not require the assistance of the resident in any way. General slings of various sizes were observed to have been available in the home at the time of inspection and according to staff, were available on the date of the incident. The home's Physiotherapist reported that the resident was referred to him for an assessment by registered staff one day prior to the incident to determine suitability for a mechanical lift for future transfers. When he went to see the resident one day after the incident, the resident had already fallen and was in pain and did not want to be assessed, however a note was made that the resident was to receive future transfers using a mechanical floor lift and appropriate sling.

As the resident was being transferred with the toileting sling, the resident slid out of the sling head first during the transfer process. According to staff member #200, she believed that a noise from the lift motor startled the resident which caused them to retract their arms from the outside of the sling to the inside, causing the weight to be displaced and the sling to tip backwards. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 218. For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Order / Ordre :

The licensee shall;

1. Appoint a person with knowledge of the home's current lift and sling equipment use instructions and who has some expertise in the correct and safe use of mechanical floor lifts and slings to provide hands on training to all health care staff who are required to use such equipment in their duties. The training program shall include a component that requires the staff member to show the trainer the correct and safe use of both the lift and sling after training has been completed.

2. Keep documentation that identifies which staff member has received the training and the date and the name of the trainer. If any staff member cannot demonstrate the safe and correct use of the equipment and slings, the person shall not use the equipment and sling.

3. Make readily available the manufacturer's sling and mechanical floor lift user guides to all staff using such equipment for reference.

Grounds / Motifs :

1. The licensee did not ensure that all staff received training in the safe and correct use of equipment including mechanical lifts and associated accessories before performing their responsibilities.

According to the Staff Development Nurse, the registered and non-registered staff received written instructions on proper body mechanics and ergonomics on how to use mechanical lifts during their orientation. The staff member was then paired up with an existing staff member who was responsible for showing them how to use the mechanical lifts and associated slings. At no point were staff assessed to determine if they were trained to use the lift and slings safely and correctly by a manager or person with some expertise in the use of the lifts and slings. According to staff interviews, many who have been employed for more than 10 years and were appointed to train new staff members, had not received training themselves since they first started. During the inspection, no lift and sling user manuals or guide books were readily available to staff for reference with the exception of a guide book titled "Passive Clip Slings" dated November 2011. The guide book was in the possession of the Clinical Co-ordinator who was tasked with providing residents with the appropriate sling size. Other reference guides for inspecting the slings were found post inspection with maintenance staff. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

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

Issued on this 11th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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