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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2016	2016_405189_0005	009328-16, 005786-16	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Fieldstone Commons Care Community
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

NICOLE RANGER (189)

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): April 7, 9, 11, 2016

This Critical Incident Inspection is related to improper transferring and positioning techniques.

The following intakes were inspected concurrently during this inspection: Critical Incident (CI) intake #005786-16, #009328-16,

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care(Interim), Assistant Director of Care (ADOC), Nurse Manager, registered staff, personal support workers, resident.

During the course of the inspection, the inspector conducted a tour of the unit, observed resident and staff interactions, reviewed clinical health records, and relevant home policies and procedures.

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The following in related to Log #009328-16

A Critical Incident was submitted by the home indicating that on an identified date, resident #001 was injured while being transferred via mechanical lift.

Review of the written plan of care for resident #001 reveals that the resident requires two staff to transfer via mechanical lift.

On an identified date, PSW #100 was assigned to provide care to resident #001. PSW #100 reported to the inspector that ,he/she fed the resident in bed, then provided personal care to the resident. Once the morning care was completed, the PSW needed to transfer the resident out of bed. PSW #100 reported that he/she was unable to find other staff to assist him/her, so he/she placed the transfer sling underneath the resident, placed the resident's wheelchair at the side of the bed, brought the mechanical lift into the room, then applied the sling to the mechanical lift and transferred the resident out of bed without a second person to assist.

PSW #102 reported to the inspector that he/she was informed by the housekeeping staff #110 that the resident is sitting in his/her room and there is blood on the floor. PSW #102 reported that he/she went in to the room and found the resident sitting in his/her wheelchair, with blood on his/her pants and underneath the wheelchair. PSW #102 reported that he/she called registered staff #101 to assess and registered staff #101 came into the room to assess the resident. The resident was assessed by the staff and sent to hospital.

Interview with registered staff #101 and Executive Director confirmed that the PSW #100 did not use safe transferring techniques when assisting the resident and the resident sustained a serious injury . [s. 36.]

2. The following is related to Log #005786-16

The written plan of care for resident #002 , indicated that the resident requires two staff to transfer via mechanical lift.

On an identified date, PSW #104 was assigned to provide one to one care for resident #003. PSW #104 reported to the inspector that he/she was informed by registered staff #103 to assist with delivering the dinner trays to residents who are on isolation precautions in the unit. PSW #104 reported that as he/she delivered the tray to resident #002 in his/her room, the resident requested the PSW to assist him/her to transfer into his/her wheelchair. PSW #104 reported that he/she was not aware of the resident's

transfer status, and transferred the resident manually from bed to wheelchair without the use of a mechanical lift and without a second person assisting. The resident sustained bruising and pain to an identified area.

Interview with PSW #104 registered staff #103 and the Executive Director confirmed that PSW #104 transferred the resident without a second person assisting and without the use of a mechanical lift. The Executive Director confirmed that the staff did not use safe transferring techniques when assisting resident #002 with transfers. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 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.

Review of the written plan of care for resident #001 reveals that the resident requires two staff to transfer via mechanical lift.

On an identified date, PSW #100 was assigned to provide care to the resident. PSW #100 reported to the inspector that he/she transferred resident #001 from bed to wheelchair using a mechanical lift and without a second person to assist. The resident was found to have an injury to an identified area. The resident was assessed by the staff and sent to hospital.

Interview with registered staff #101, PSW #100 and Executive Director confirmed that transferring of the resident required two person with mechanical lift . The Executive Director confirmed that the care set out in the plan of care was not provided to resident #001. [s. 6. (7)]

2. The written plan of care for resident #002 indicated that the resident requires two staff to transfer via mechanical lift.

On an identified date, PSW #104 was assigned to provide one to one care for resident #003. PSW #104 reported to the inspector that he/she was informed by registered staff #103 to assist with delivering the dinner trays to residents who are on isolation precautions in the unit. PSW #104 reported that as he/she delivered the tray to resident #002 in his/her room, the resident requested the PSW to assist him/her to transfer into his/her wheelchair. PSW #104 reported that he/she was not aware of the resident's transfer status, and transferred the resident manually from bed to wheelchair without the use of a mechanical lift and without a second person assisting. The resident sustained a bruising and pain to an identified area.

Interview with PSW #104 registered staff #103 and the Executive Director confirmed that PSW #104 transferred the resident without a second person assisting and without the use of a mechanical lift. The Executive Director confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (5) Every licensee of a long-term care home shall ensure that every person mentioned in subsection (1) receives training that is provided for in the regulations in areas other than those provided for in subsection (2), at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of subsection 76 (5) of the Act, that mechanical lift and sling training was provided to all staff who provide direct care to residents.

Review of the home's training records indicated that 18 percent of staff did not complete their training on mechanical lifts and sling training for 2015.

Interview with the ADOC #105 confirmed that not all staff who provided direct care to residents received training in mechanical lifts and sling for the 2015 training period. [s. 76. (5)]

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 for the purposes of subsection 76 (5) of the Act, that mechanical lift and sling training was provided to all staff who provide direct care to residents, to be implemented voluntarily.

Issued on this 1st day of June, 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2016_405189_0005
Log No. / Registre no:	009328-16, 005786-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 4, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fieldstone Commons Care Community 1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dwayne Green

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is to prepare, submit and implement a corrective action plan to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

This plan will include but not limited to:

1) Ensuring that mechanical lift transfers are conducted by a minimum of two staff.

2) Include methods for monitoring front line staff, to ensure that they comply with the home's transfer and lifts policies, and with residents' individual plans of care.

3) Provide education to all direct care staff regarding safe transferring and positioning techniques, the types of lifts used in the home for transferring residents, and a review of the criteria for the use of each lift.

Plan to be submitted to nicole.ranger@ontario.ca by May 13, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The following is related to Log #005786-16

The written plan of care for resident #002 , indicated that the resident requires two staff to transfer via mechanical lift.

On an identified date, PSW #104 was assigned to provide one to one care for resident #003. PSW #104 reported to the inspector that he/she was informed by registered staff #103 to assist with delivering the dinner trays to residents who are on isolation precautions in the unit. PSW #104 reported that as he/she delivered the tray to resident #002 in his/her room, the resident requested the PSW to assist him/her to transfer into his/her wheelchair. PSW #104 reported that he/she was not aware of the resident's transfer status, and transferred the resident manually from bed to wheelchair without the use of a mechanical lift and without a second person assisting. The resident sustained bruising and pain to an identified area.

Interview with PSW #104 registered staff #103 and the Executive Director confirmed that PSW #104 transferred the resident without a second person assisting and without the use of a mechanical lift. The Executive Director confirmed that the staff did not use safe transferring techniques when assisting resident #002 with transfers. [(189)

2. The following in related to Log #009328-16

A Critical Incident was submitted by the home indicating that on an identified date, resident #001 was injured while being transferred via mechanical lift.

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PSW #102 reported to the inspector that he/she was informed by the housekeeping staff #110 that the resident is sitting in his/her room and there is blood on the floor. PSW #102 reported that he/she went in to the room and found the resident sitting in his/her wheelchair, with blood on his/her pants and

underneath the wheelchair. PSW #102 reported that he/she called registered staff #101 to assess and registered staff #101 came into the room to assess the resident. The resident was assessed by the staff and sent to hospital.

Interview with registered staff #101 and Executive Director confirmed that the PSW #100 did not use safe transferring techniques when assisting the resident and the resident sustained a serious injury . [s. 36.]

(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 4th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

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