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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2019	2019_703625_0012	031660-18, 033452-18, 009197-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

KATHERINE BARCA (625)

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): June 4 to 7, 2019.

The following intakes were inspected during this inspection:
- log #009197-19, related to Critical Incident System (CIS) report #2866-000004-19, submitted for resident to resident abuse; and
- logs #031660-18 and #033452-18, related to CIS reports #2866-000013-18 and #2866-000014-18, respectively, submitted for two falls which resulted in significant changes in the health condition of two residents.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Resident Assessment Instrument (RAI) Coordinator, a Therapeutic Recreation employee, the Program Manager, the Business Office Manager, a Physiotherapy Assistant, a Maintenance employee, the Environmental Services Manager (ESM), an Associate Director of Care (ADOC), the Director of Care (DOC) and the Executive Director (ED).

The Inspector observed the care and services provided to residents, staff to resident interactions, and resident to resident interactions. The Inspector also reviewed residents' health care records, home's policies and programs, home's investigation files and staff schedules.

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

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
5 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 used safe transferring and positioning techniques when assisting resident #001.

A CIS report was submitted to the Director for a fall that occurred in the fall of 2018, which resulted in resident #001 sustaining injuries. The CIS report identified that resident #001 had been sitting up at their bedside when they fell off their bed.

(a) A review of resident #001's care plan in place at the time of the fall, included an intervention initiated in the winter of 2015, which identified the resident was to perform a specific activity of daily living (ADL) while lying down.

During an interview with resident #001 about their fall, they stated that a PSW helped them with an ADL while they sat up on the edge of the bed, then they fell forward off the bed and onto the floor.

During an interview with PSW #119, they stated that they had been with resident #001 during the fall. The PSW stated they went into the resident's room and sat the resident on the side of the bed, with one of their hands holding their bed rail. The PSW stated they had intended to bring a mechanical lift closer to the resident so the resident could hold onto it while seated at the edge of the bed. The PSW stated the resident would hold both the bed rail and mechanical lift while participating in specific ADLs. The PSW stated that the resident's care plan was incorrect when it identified the resident lay in bed to complete and ADL as staff never did that, they had all sat the resident on the edge of their bed when completing the ADLs.

During an interview with PSW #125, they indicated that the mechanical lift should not be used as something for a resident to hold onto when they are seated at the side of their bed. The PSW stated that if residents required care in bed, they were provided with the care while lying down.

During an interview with the DOC, they reviewed resident #001's care plan in place at the time of the fall and indicated that staff should not have sat the resident on the edge of the bed to complete an ADL, that the mechanical lift should not have been used for the resident to hold on to while seated on the bed while care was provided, and that the positioning and use of the lift in that manner was not a safe positioning technique.

(b) A review of resident #001's current care plan identified the resident's bed height was to be in the low position while the resident was in bed, as a falls related intervention.

A review of the home's policy titled "Mechanical Lift Procedure – LP-01-01-03", last updated August 2017, identified staff were to remain with the resident during the entire

time the sling was connected to the mechanical lift.

On a date during the inspection, Inspector #625 observed resident #001 lying in bed in a sling that was connected to a mechanical lift. The bed was elevated and the mechanical lift brakes were unlocked. PSW #125 entered the room after approximately two minutes had passed, saw the Inspector, and then left the room for a second time for approximately another two minutes.

During an interview with resident #001, they indicated that staff usually left the resident unattended and connected to the lift in the manner observed by the Inspector.

During an interview with PSW #125, they stated that they had left resident #001 in the state the Inspector observed to find someone to help transfer the resident.

During an interview with PSW #116, they stated two staff were needed for all transfers (using mechanical lifts) and they had assisted PSW #125 get the sling under resident #001 and then left to help a co-worker. The PSW reviewed resident #001's current care plan that identified the bed was to be in a low position when the resident was in bed, and indicated the height of resident #001's bed when the sling was connected to the mechanical lift was not the low position.

During an interview with the DOC, they indicated that leaving a resident unattended, connected to a mechanical lift via a sling as observed by the Inspector, was not a safe positioning technique, and that leaving resident #001 in a bed not in low position was not in accordance with their care plan and was not a safe positioning technique.

(c) A review of resident #001's current care plan identified the resident required the assistance of two staff to assist with transfers using a mechanical lift, including one staff to support and maneuver parts of the resident's body throughout the transfer, as well as the RPN or RN to assist as needed.

A review of the home's policy titled "Mechanical Lift Procedure – LP-01-01-03", last updated August 2017, identified that, when using a specific type of mechanical lift, a second staff person was required to steady the resident.

On a date during the inspection, Inspector #625 observed PSW #125 and RPN #124 transfer resident #001 from one location to another. The RPN did not physically participate in the transfer. The PSW raised the resident in the lift, pivoted the lift, and

lowered the resident. The resident's specific body parts were not supported and maneuvered by one staff throughout the transfer, and the RPN did not steady the resident during the transfer.

During an interview with the DOC, they stated that two staff were required to operate mechanical lifts in the home. The DOC indicated the staff performing the lift observed by the Inspector did not perform the transfer in accordance with resident #001's current care plan if the resident's specific body parts were not supported and maneuvered throughout the transfer, the transfer was not in accordance with the Safe Lifting with Care Program as the second staff person did not steady the resident, and the method of transferring resident #001 observed by the Inspector was not a safe transferring technique. [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. (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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident, with respect to the use of fall management equipment and mechanical lift slings.

A CIS report was submitted to the Director for a fall sustained by resident #002 in the winter of 2018, for which they were taken to hospital and resulted in an injury. The report identified the resident had falls interventions in place including the use of both one and more than one piece of the same falls management equipment.

(a) A review of resident #002's current care plan identified interventions to minimize the risk of falls including the use of more than one piece of falls management equipment and the use of only one piece of the same fall management equipment, but did not specify the required placement if only one piece of equipment was used. The intervention was initiated on a date in the winter of 2018.

On two dates during the inspection, Inspector #625 observed one piece of falls management equipment in resident #002's room.

During an interview with PSW #110, they stated that the resident's current care plan was not clear if the resident used one or more than one piece of falls management equipment, or where the one piece of equipment was to be placed if only one was to be used.

During an interview with RPN #111, they stated that the resident's care plan was not clear as it listed that pieces of falls management equipment, plural, as well as one piece of equipment was used, but did not actually specify the placement if only one piece of equipment was to be used.

During an interview with RN #113 on a date during the inspection, they stated that they had provided resident #002 with one piece of falls management equipment the previous date, and believed there had been one piece of equipment in place the entire time the resident's care plan listed both one and more than one piece of equipment were used. The RN reviewed the current care plan and identified that it listed pieces of falls management equipment, plural, as an intervention. The RN stated resident #002's care plan needed to be updated to reflect that resident #002 only required one piece of falls management equipment and that it was to be placed in a specific location.

During an interview with ADOC #103, they stated that resident #002's current care plan was not clear as to the number pieces of falls management equipment in use, and the placement if only one piece of equipment was used.

During an interview with the DOC, they stated that resident #002's current care plan was not clear as to whether staff were to use one or two pieces of falls management equipment and, if only one was to be used, it was not clear where it was to be placed.

(b) Inspector #625 reviewed resident #002's Safe Lift and Transfer Assessments dated

the winter of 2019, which indicated the resident required a one colour and size of sling, and the spring of 2019, which indicated the resident required a different colour sling.

On a date during the inspection, the Inspector observed a transfer logo for a mechanical lift inside the resident’s closet door. A circle with a specific colour of edging and a size written on it was affixed to the logo.

The Inspector was not able to locate information on the size or colour of the required sling in the resident’s care plan.

Inspector #625 reviewed the home’s policy titled “Mechanical Lifts Procedure – LP-01-01 -03”, last updated August 2017, which identified pre-transfer, staff were to gather the appropriate sling identified on the care plan and ensure it was the correct size, correct type and correct supplier.

During an interview with PSW #110, they stated they used either one colour of sling or another colour of sling to transfer resident #002, they were not sure which one was which size, but most residents on the home area used one specific size of sling. The PSW stated that, if the sling sticker inside the door had a specific coloured edge and read a specific size, but the most recent assessment said a different coloured sling was to be used, and the care plan did not specify the sling size to use, staff would need to clarify which sling was to be used because it was not clear.

During an interview with ADOC #103, they stated that the closet door listed one size of sling was to be used; the last Safe Lift and Transfer Assessment dated the spring of 2019, listed a [contradictory] colour of sling was to be used; and the care plan did not list the colour or size of the sling to be used. The ADOC indicated the plan of care was not clear to staff as to what colour or size of sling was required.

During an interview with the DOC, they acknowledged that the plan of care indicated one colour of sling was to be used as posted on resident #002’s closet door, and the use of another colour of sling was listed in their most recent Safe Lift and Transfer Assessment. The DOC indicated that it was not clear to staff as to which color of sling the resident used. The DOC stated the colour and size of slings should not be listed in resident care plans, but care plans should direct staff to look in the residents' closets for sling use information. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for resident

#001 that set out clear directions to staff and others who provided direct care to the resident, with respect to mobility and the use of mechanical lift slings.

A CIS report was submitted to the Director for a fall that occurred in the fall of 2018, which resulted in resident #001 sustaining injuries.

(a) Inspector reviewed resident #001's current care plan, under the focus of "requires support for mobility…as evidenced by…Physical limitations…recent [fall related injuries]". Mobility interventions listed included that the resident required staff assistance with locomotion, revised in the winter of 2019, as well as required encouragement to self mobilize, with reminders to use mobility aids for assistance, revised in the fall of 2018.

During an interview with RAI Coordinator #118, they reviewed resident #001's current care plan and stated that it said two different things for the resident's mobility.

During an interview with the DOC, they stated that resident #001's current care plan was not clear to staff with respect to their mobility assistance required and independence.

(b) On a date during the inspection, the Inspector observed a specific sling colour behind resident #001 while they used a mobility aid. On the next day of the inspection, the Inspector observed the resident transferred with a different coloured sling. On the following day of the inspection, the Inspector observed the same sling colour noted the previous date underneath the resident while they used a mobility aid. The different sling colours corresponded to different sling sizes.

Inspector #625 reviewed resident #001's Safe Lift and Transfer Assessments completed in the fall of 2018, which identified the resident used the same coloured sling observed by the Inspector on the second and third consecutive dates of the inspection, and that the sling was a specific size; and dated the winter of 2019, which identified the resident used a sling of a third colour, not observed in use with the resident by the Inspector.

On a date during the inspection, the Inspector observed a colour written in ink on the resident's transfer status logo inside their closet. The colour corresponded to the sling colour the Inspector observed used by the resident on the second and third consecutive observations of the sling colour made during the inspection.

The resident's current care plan did not list the colour or size of sling the resident used.

During an interview with RPN #120, they confirmed the Safe Lift and Transfer Assessment dated the winter of 2019, identified the resident required one coloured sling (not observed by the Inspector to be used with the resident during the inspection), but another coloured sling (not assessed for use with the resident in either assessment) was positioned under the resident as they use a mobility aid. The RPN obtained a coloured sling that corresponded to the colour listed in the most recent assessment to use.

During an interview with the RAI Coordinator #118, they confirmed the most recent Safe Lift and Transfer Assessment, completed in the winter of 2019, identified the resident required one coloured sling. They also stated the sling colour was not listed on the resident’s current care plan, they didn’t believe the sling colour was entered in residents' care plans, but that the logos in the residents’ room may specify the sling type.

During an interview with the DOC, they stated that the person who had completed resident #001’s most recent Safe Lift and Transfer Assessment should have updated the closet logo as well. The DOC stated that the residents’ care plans did not contain information on sling types, to avoid having the care plans potentially conflict with the logos in residents' rooms. The DOC identified that the plan of care was not clear as to whether which sling colour should be used for resident #001’s transfers. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of resident #002, so that their assessments of the resident's weight bearing status and level of assistance required with transfers, were integrated and were consistent with and complemented each other.

A CIS report was submitted to the Director for a fall sustained by resident #002 in the winter of 2018, for which they were taken to hospital and which resulted in an injury.

Inspector #625 reviewed a Safe Lift and Transfer Assessment dated the winter of 2019, which identified resident #002 was not able to fully weight bear, was able to partially weight bear, and required a mechanical lift with two staff for transfers. A Physiotherapy Assessment dated the same date, identified resident #002 was able to fully weight bear and required the assistance of one person to transfer, as well as required two staff for transfers elsewhere in the assessment.

The Inspector also reviewed a Physiotherapy Assessment dated the spring of 2019, which indicated the resident was non-weight bearing, and a Safe Lift and Transfer

Assessment dated four days later, that identified the resident was able to partially weight bear.

During an interview with ADOC #103, they reviewed the:
- Safe Lift and Transfer assessment dated the winter of 2019, completed by RPN #126, which indicated the resident was able to partially weight bear and required two staff assistance to transfer using a mechanical lift;
- Physiotherapy Assessment dated the same date in the winter of 2019, completed by PT #127, which indicated the resident was able to fully weight bear with one person assistance;
- Physiotherapy Assessment dated the spring of 2019, completed by PT #127, that identified the resident was non-weight bearing and required a mechanical lift to transfer; and
- Safe Lift and Transferring Assessment dated four days later in the spring of 2019, completed by RAI Coordinator #118, that identified the resident was able to partially weight bear and used a mechanical lift.

The ADOC stated the assessments dated the winter of 2019, identified the resident had both full weight bearing and also partial weight bearing capabilities, and required both one person and two person transfer assistance. The ADOC stated the assessments dated the spring of 2019, identified the resident had both non-weight bearing and partially weight bearing capabilities. The ADOC stated the assessments were not consistent with each other.

During an interview with the DOC, they reviewed the assessments dated the winter of 2019, and stated they were not integrated, consistent with or complementary to each other with respect to weight bearing status and number of staff required to assist the resident with transfers. The DOC reviewed the assessments dated the spring of 2019, and stated that a resident must be able to at least partially weight bear to use a particular type of mechanical lift, and that the two assessments were not consistent with respect to the resident's weight bearing status. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of resident #001, so that their assessments of the resident's pain, falls and bed rail use, were integrated and were consistent with and complemented each other.

A CIS report was submitted to the Director for a fall that occurred in the fall of 2018, which resulted in resident #001 sustaining injuries. The report identified the resident fell

out of bed, and required a bed rail to help with turning and repositioning in bed, required a mechanical lift for transfers, and staff were monitoring the resident's pain.

(a) Inspector #625 reviewed a Canadian Continuing Care Reporting System (CCRS) Minimum Data Set (MDS) 2.0 significant change in status assessment dated eight days after the resident's fall. The assessment did not identify the resident fell in the past 30 days, but identified the resident had no pain present in the previous seven days.

A review of resident #001's progress notes identified that the resident fell on a date in the fall of 2018, sustained injuries, and experienced pain related to the injuries.

A review of the documented pain levels on the resident's electronic Medication Administration Records (eMARs) for a month in 2018, identified the resident experienced pain daily for seven consecutive dates.

During an interview with RAI Coordinator #118, they stated that the CCRS MDS assessment, completed on the seventh consecutive date the eMAR identified the resident experienced pain, did not indicate the resident fell in the last 30 days and did not indicate the resident had experienced pain. They indicated that the assessment should have identified the resident fell in the past 30 days and had pain daily.

During an interview with the DOC, they indicated that the staff involved in the different aspects of care of the resident had not collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, with respect to assessment of resident #002's pain and fall.

(b) On two dates during the inspection, Inspector #625 observed one bed rail on resident #001's bed.

During an interview with resident #001, they stated that they were scared of falling again and wanted two bed rails, but had not had two bed rails since moving to their room.

During an interview with PSW #122, they stated that resident #001 needed two bed rails for turning in bed. The PSW stated the use of two bed rails was in the resident's care plan and the resident's family member requested it but the resident had never had two bed rails. The PSW identified that, when staff turned the resident in bed, the resident pushed back as they were scared of falling.

During an interview with PSW #121, a member of the home's Safe Lift Team, they stated they had requested a second bed rail be installed on resident #001's bed, the Physiotherapist did an assessment and also said that a second bed rail on the bed should be installed. The PSW stated that the resident required the bed rails.

Inspector #625 reviewed resident #001's health care record with a focus on bed rail use, including:
- a Bedrail and Entrapment Risk Assessment dated the spring of 2019, and the current care plan which included an intervention created on the same date in the spring of 2019, for the use of one bed rail;
- a Physiotherapy Referral dated eight days prior, which identified RN #113 submitted the referral as the resident required a second bed rail in bed. The response from PT #127 included a recommendation for a second bed rail on the bed, and that the ESM had been sent an email with that information;
- the care plans in place at the time of the resident's fall and following the resident's fall, which both listed the use of two bed rails "as per POA...request", initiated in the winter of 2015;
- a Side Rail and Alternative Equipment Decision Tree which identified the resident used two bed rails and, in the summer of 2015, the resident's "POA contacted. POA refused removal of side rails".

During an interview with RAI Coordinator #118, they reviewed resident #001's care plans and stated that the care plans from the winter of 2015, (the date of the initiated bed rail intervention) to a date in the spring of 2019, listed that the resident used two bed rails as per the "POA" request. The RAI Coordinator stated that they had completed the Bedrail and Entrapment Risk Assessment dated the spring of 2019, and had updated the care plan the same date to include the bed rail intervention as one bed rail. The RAI Coordinator stated they had not seen the Rehab – PT Referral dated eight days prior, that recommended the resident also use a second bed rail. They stated they updated the assessment and care plan to list one bed rail as that is what they had observed on the resident's bed, and that the assessments of the bed rails used were not consistent with or complementary to each other.

During an interview with the ESM, they stated that resident #001 had two bed rails in use several years earlier. They identified that home had completed a blitz and removed all of the bed rails from every resident to mitigate the entrapment risk, and resident #001 went without any bed rails for multiple weeks at that time. The ESM stated the resident's family member requested bed rail use and the home put the one bed rail on the bed. The ESM

stated they had not received communication from the Physiotherapist to have a second bed rail put on the resident's bed.

During an interview with the DOC, they identified that resident #001's historical use of bed rails detailed by the ESM was accurate. The DOC indicated that the resident's care plan going back to the summer of 2018 listed two bed rails as per "POA" request, which would have been in the care plan since the winter of 2015. The DOC reviewed resident #001's current care plan that listed the use of one bed rail; Bedrail and Entrapment Risk Assessment dated the spring of 2019, that identified the use of one bed rail; and the RN referral to the PT dated eight days before the Bedrail and Entrapment Risk Assessment had been completed, which recommended the use of a second bed rail to benefit the resident. The DOC indicated that the staff involved in the different aspects of care of resident #001 had not collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, with respect to the number of bed rails the resident required. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the care related to the use of falls management equipment set out in resident #002's plan of care was provided to the resident as specified in the plan .

A CIS report was submitted to the Director for a fall sustained by resident #002 in the winter of 2018, for which they were taken to hospital, and which resulted in an injury. The report identified the resident had falls interventions in place including the use of pieces of falls management equipment, as well as used one piece of the same falls management equipment.

A review of resident #002's current care plan identified interventions to minimize the risk of falls including the use of pieces of falls management equipment initiated in the fall of 2018, as well as one piece of the same falls management equipment which did not specify the location of the equipment initiated in the winter of 2018.

On a date during the inspection, the Inspector observed resident #002 with no piece/pieces of falls management equipment in use.

During an interview with PSW #112, they stated that they had worked on that home area for multiple months, had provided care to resident #002, and had not seen the specific falls management equipment in use for the resident during that time.

During an interview with PSW #110, they stated that resident #002 had not had the falls management equipment in use since before they returned from hospital after their injury, in the winter of 2019.

During an interview with RPN #115, they attended resident #002's room with Inspector #625 and confirmed there were no pieces of falls management equipment in the resident's room. The RPN called RN #113 to discuss the absence of the equipment then informed the Inspector that the RN didn't know why the equipment was removed either but would get one for the resident.

During an interview with RN #113 on a date during the inspection, they stated that they had provided one piece of equipment to resident #002 the previous date. The RN stated that the resident's fall management equipment may have been removed from their room when they had returned from hospital, or when the resident believed they were moving elsewhere.

During an interview with the DOC, they stated that staff had not provided care to resident #002 as per the plan of care with respect to the falls management equipment if they were not using the equipment with the resident. [s. 6. (7)]

6. The licensee has failed to ensure that resident #002 was reassessed and their plan of care reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary, with respect to their use of falls prevention equipment and the positioning of the resident's door.

(a) A CIS report was submitted to the Director for a fall sustained by resident #002 in the winter of 2018, for which they were taken to hospital, and which resulted in an injury. The CIS report identified the resident used a piece of falls prevention equipment.

A review of resident #002's current care plan identified an intervention for the falls prevention equipment, initiated in the winter of 2018, to minimize the risk of falls.

During an interview with RPN #111, they stated that resident #002 did not have the falls prevention equipment in their room. The RPN reviewed the resident's current care plan and stated that it needed to be updated as the equipment was not required.

During an interview with ADOC #103, they attended resident #002's room with the Inspector and stated that the falls prevention equipment was not in the room. The ADOC

stated the resident's care plan needed to be updated to reflect their current assessed needs, which did not include the use of the specific falls prevention equipment.

During an interview with the DOC, they reviewed resident #002's current care plan and stated that it was not up-to-date with respect to the resident's current needs related to the use of specific falls prevention equipment.

(b) The CIS report also identified that the resident had fallen in the past while positioning their door and an intervention in place prior to the fall was that staff were to keep the door in a particular position as per resident #002.

A review of resident #002's current care plan identified an intervention, initiated in the fall of 2018, to minimize the risk of falls, which indicated that the resident had fallen in the past while positioning their door and that staff were to keep the door in a specific position as per resident #002's preference.

During observations of resident #002's room, Inspector #625 noted a sign affixed to the door that directed staff to keep the door in a particular position as preferred by the resident.

During observations of resident #002 on a date during the inspection, they were in their room and the door was not in the position identified in the plan of care. When asked by the Inspector, the resident stated they wanted their door positioned differently. On the following date, the resident's door was again observed in a position other than that identified in the plan of care. During interviews with resident #002, they had stated to the Inspector that they wanted their bedroom door kept in a different position than that listed in their plan of care.

During an interview with RPN #111, they stated that the sign affixed to the resident's door should be updated if the resident no longer wanted their door in the specified position all the time. The RPN stated the sign should direct staff to ask the resident how they wanted their door positioned.

During an interview, RN #113 stated that, before resident #002's fall, the resident used to position their door in a specific manner. The RN stated that, prior to their fall, the resident had liked to have their door in a the position listed in their plan of care.

During an interview with ADOC #103, they approached resident #002 with the Inspector

and asked the resident how they wanted their door positioned. The resident responded that they wanted their door in a position other than that listed in their plan of care, and did not want it in the position listed in their plan of care all the time.

During an interview with the DOC, they stated that resident #002's care plan had not been updated to reflect the position that the resident's door was to be in. [s. 6. (10) (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 that ensures that:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
- 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen and accessed by resident #001 at all times.

A CIS report was submitted to the Director for a fall that occurred in the fall of 2018, which resulted in resident #001 sustaining injuries. The CIS report identified that resident #001 fell from their bed.

A review of resident #001’s current care plan identified staff were to ensure the resident’s call bell was within reach, as a falls related intervention.

On a date during the inspection, Inspector #625 observed resident #001 lying in bed with their call bell on the floor, inaccessible to the resident. PSW #125 entered the room after approximately two minutes had passed, saw the Inspector, and then left the room for a second time for approximately another two minutes. The call bell remained on the floor, inaccessible to the resident.

During an interview with resident #001, they indicated that they could not reach their call bell.

During an interview with PSW #125, when asked about the call bell laying on the floor, the PSW stated they had just left to get help from staff with the transfer.

During an interview with PSW #116, they indicated that resident #001 should have their call bell within their reach at all times when in bed.

During an interview with the DOC, they indicated that resident #001’s call bell should have been easily seen and accessed by the resident when the Inspector had observed it on the floor. [s. 17. (1) (a)]

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 that ensures that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of resident #004's behaviour patterns, identified responsive behaviours, and potential behavioural triggers.

A CIS report was submitted to the Director for resident to resident physical abuse. The report identified that resident #003 exhibited a responsive behaviour to resident #004, and resident #004 became verbally aggressive and physically aggressive which resulted in an an injury to resident #003.

A review of resident #003’s progress notes from dates in the spring of 2019, identified that on:
- one date, resident resident #004 was angry at resident #003;
- on the same date, resident #003 was in close proximity to resident #004 and resident #004 was getting angry;
- on the same date, resident #003 was in close proximity to resident #004, while resident #004 attempted to get away from resident #003;
- on a second date, resident #004 was verbally aggressive to resident #003;

- on a third date, resident #004 was physically and verbally aggressive with resident #003;
- on a fourth date, resident #004 became upset, demonstrating this physically to resident #003;
- on a fifth date, resident #004 was physically aggressive with resident #003 during multiple interactions; and
- on a sixth date, resident #004 was verbally and physically aggressive with resident #003 and resident #003 sustained an injury.

Resident #004’s progress notes were also reviewed from the same dates in the spring of 2019, and contained entries dated the third and fifth dates of resident #003's entries, which were consistent with those entries in resident #003’s progress notes.

A review of the home’s policy titled “Responsive Behaviours – RC-17-01-04”, last updated February 2017, indicated that each resident was to be assessed and observed for indicators of responsive behaviours as needed; all new or escalated instances of responsive behaviours would be recorded; and the home would implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours.

Inspector #625 reviewed resident #004’s care plan in place prior to the incident on the spring of 2019, and was not able to locate any reference to interdisciplinary assessment of the resident’s behaviour patterns, any identified responsive behaviours, or any potential behavioural triggers.

A review of resident #004’s current care plan identified interventions to address physically aggressive behaviours related to a behaviour exhibited by resident #003, initiated the date after resident #003 was physically abused by resident #004.

During an interview with the DOC, they indicated that resident #004’s plan of care had not contained interventions related to the physical aggression demonstrated to resident #003 prior to the incident on that occurred in the spring of 2019. The DOC identified that interventions related to physical aggression were developed and included in resident #004’s plan of care the day following the incident between the residents. The DOC acknowledged that, on the day of the incident, resident #004’s plan of care was not based on an interdisciplinary assessment of behaviour patterns, including identified responsive behaviours and potential behavioural triggers. [s. 26. (3) 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 that ensures that the plan of care is based on, at a minimum, interdisciplinary assessment, with respect to the resident, of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: 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 has failed to ensure that when resident #001 fell, the resident was assessed and that where the condition or circumstance of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director for a fall that occurred in the fall of 2018, which resulted in resident #001 sustaining injuries.

Inspector #625 reviewed resident #001's health record and was not able to locate a post-fall assessment completed for that fall.

The home's policy titled "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, identified that, post-fall, staff were to complete a post-fall assessment as soon as possible.

During an interview with PSW #119, they stated that they were providing care to resident #001 while the resident fell to the floor.

During an interview with RAI Coordinator #118, they stated that a post-fall assessment had not been completed for resident #001's fall in the fall of 2018. The RAI Coordinator stated that management investigating the incident "weren't counting it as a fall". The RAI Coordinator stated that the home's policy required staff to complete a post-fall assessment tool as soon as possible following a fall.

During an interview with the DOC, they acknowledged that resident #001 had fallen and that the direction from management at the time of the fall was that the incident was not a fall as the PSW present guided the resident to the floor. The DOC stated that the thinking was that the PSW did intend for the resident to go to the floor. The DOC stated that they had provided incorrect information to staff as their direction would have been that a fall had not occurred, which was incorrect according to the home's current policy. [s. 49. (2)]

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 that ensures 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures related to documentation of resident #004's observed behaviours were implemented to assist residents who were at risk of harm or who were harmed as a result of a resident #004's behaviours, including responsive behaviours.

A CIS report was submitted to the Director for resident to resident physical abuse. The report identified that resident #003 exhibited a responsive behaviour to resident #004, and resident #004 became verbally aggressive and physically aggressive which resulted in an an injury to resident #003.

A review of resident #003’s and resident #004’s progress notes from dates in the spring

of 2019, identified that resident #004's health care record did not include documentation of their behaviours, which had been documented in resident #003's progress notes, on:
- one date, when resident #004 was angry at resident #003;
- on the same date, when resident #004 was attempting to get away from resident #003, and was getting angry with them for being in close proximity and holding them;
- on a second date, when resident #004 was verbally aggressive to resident #003;
- on a third date, when resident #004 became upset, demonstrating this physically to resident #003; and
- on a fourth date, when resident #004 was verbally and physically aggressive with resident #003 and resident #003 sustained an injury.

A review of the home's policy titled "Responsive Behaviours – RC-17-01-04", last updated February 2017, indicated as a procedure, that the nurse was to complete accurate documentation in the resident's health record when behaviours were observed. The documentation was to clearly describe any identified triggers to the behaviour; how the behaviour was displayed; what was observed in the immediate surroundings; what interventions were tried; what interventions were unsuccessful or successful; additional actions taken by the staff or others; and any negative experience or outcome for the resident or other person/resident.

During an interview with the DOC, they stated that staff should have documented resident #004's behaviours including physical aggression and verbally aggression demonstrated towards resident #003. The DOC stated that the behaviours exhibited by resident #004 on the dates previously identified by the Inspector, had not been documented in their health record. The DOC indicated that the procedures listed in the home's responsive behaviours policy had not been implemented with respect to completion of accurate documentation in resident #004's health record. [s. 55. (a)]

2. The licensee has failed to ensure that interventions were implemented to assist residents who were at risk of harm or who were harmed as a result of resident #003's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among resident #003 and other residents.

A CIS report was submitted to the Director for resident to resident physical abuse. The report identified that, in the spring of 2019, resident #003 was physically abused by resident #004. The report detailed that resident #003 required a particular level of staffing at the time of the incident to address specific responsive behaiours involving resident #004. The report identified that the required level of staffing had not been provided to

resident #003 at the time of the incident, as the staff person responsible for the monitoring went on a break and the regular scheduled unit staff had not provided the required level of staffing. The report also identified that immediate actions taken to prevent recurrence included education provided to staff including Dementia Observation System (DOS) completion and following the care plan.

(a) A review of the home's policy titled "Responsive Behaviours – RC-17-01-04", last updated February 2017, indicated that, as a procedure, care staff were to be consistent in the application and implementation of specific interventions related to behaviours; were to provide close observation of the resident with responsive behaviours; and if the behaviour posed a risk to the resident or others, the resident was to be monitored carefully and staff were to follow the care plan which outlined the frequency of resident observations for safety.

A review of resident #003's care plan in place at the time of the incident, in the spring of 2019, identified that the resident required a particular level of staffing daily, over specific hours. The intervention was initiated in the care plan four days before the incident with resident #004 had occurred.

During an interview with PSW #105 they stated that they had worked on the shift the incident of physical abuse from resident #004 to resident #003 had occurred, and had been told by other direct care staff that the incident happened when no one had been providing resident #003 with the required level of staffing.

During an interview with the DOC, they acknowledged that, in the spring of 2019, resident #003 required a level of staffing as listed in their care plan, over specific hours, daily. The DOC stated that the monitoring associated with the required level of staffing had not been provided to resident #003 at the time of the incident, during a staff break. The DOC acknowledged that the intervention for the level of staffing and monitoring, an intervention implemented to minimize the risk of altercations and potentially harmful interactions between residents #003 and #004, had not been implemented at the time of the incident.

(b) A review of the home's policy titled "Responsive Behaviours – RC-17-01-04", last updated February 2017, indicated that, as a procedure, care staff were to complete documentation of each episode of behaviour on each shift for all residents observed to display responsive behaviours. Staff were to use the DOS tool if determined appropriate.

A review of resident #003's current care plan identified an intervention for completion of a DOS on all three shifts.

On a date during the inspection PSW #107 informed Inspector #625 that resident #003 had exhibited a responsive behaviour to resident #004 a short time earlier, and the PSW had immediately responded and intervened.

On the same date, RPN #106 informed the Inspector that resident #003 had recently exhibited a responsive behaviour to resident #004 and resident #004 had been verbally aggressive to resident #003. The RPN stated the staff person providing the required level of staffing was present and intervened.

Inspector #625 was not able to locate documentation in Point Click Care (PCC) of the incident that occurred the previous date, and found the corresponding DOS blank from specific hours, the period of time when the reported incident between the residents had occurred.

During an interview with PSW #105 on the date following the incident, they stated that RPNs were required to document in PCC if resident #003 tried to get into resident #004's room or opened the door. The PSW also stated that the staff member providing the level of monitoring was required to document on the DOS, and acknowledged that the previous date's DOS was blank over certain hours.

During an interview with RPN #106 on the date following the incident, they reviewed the PCC documentation and acknowledged that they had not documented a progress note of the interaction between residents #003 and #004, which they had reported to the Inspector the previous date.

During an interview with the DOC, they acknowledged the intervention to complete the DOS, an intervention implemented to minimize the risk of altercations and potentially harmful interactions between residents #003 and #004, had not been implemented on the date resident #003 was reported to have demonstrated responsive behaviours. [s. 55. (a)]

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 that ensures that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of resident #003 had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director in the spring of 2019, for resident to resident physical abuse that occurred the previous date, 18 hours prior. The report identified that resident #003 exhibited a responsive behaviour to resident #004, and resident #004 became verbally and physically aggressive, resulting in an injury to resident #003.

Inspector #625 was not able to locate any notification to the Director that occurred prior to the submission of the CIS report.

A review of resident #003’s progress notes identified that resident #003 and resident #004 had an interaction which resulted in an injury to resident #003.

During an interview with the DOC, they stated that staff should have called the After-Hours Line to notify the Director immediately after the incident occurred. The DOC stated the incident had not been reported to the Director until the CIS report was submitted the following day. [s. 24. (1) 2.]

Issued on this 5th day of July, 2019

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) :	KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2019_703625_0012
Log No. / No de registre :	031660-18, 033452-18, 009197-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 28, 2019
Licensee / Titulaire de permis :	CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Southbridge Roseview 99 Shuniah Street, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joanne Lent

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

To CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 36 of Ontario Regulation 79/10.

Specifically, the licensee must:
a) Ensure that resident #001's written plan of care is current with respect to the safe positioning of the resident during the provision of care, specifically during two particular activities of daily living (ADLs); the safe positioning of the resident when they are in bed; the safe positioning of the resident when a mechanical lift sling is used; and the safe transferring of the resident;
b) Ensure the staff that provide direct care to resident #001 are aware of, and provide care in accordance with, the resident's written plan of care with respect to positioning of the resident during two specific ADLs; safe positioning of the resident when they are in bed; safe positioning of the resident when a mechanical lift sling is used; and the safe transferring of the resident;
c) Ensure the staff that provide direct care to resident #001 have received orientation and retraining in the safe and correct use of equipment, including mechanical lifts, assistive aids and positioning aids, that is relevant to the staff members' responsibilities, in accordance with s. 218 and s. 219 of Ontario Regulation 79/10; and
d) Ensure the staff that provide direct care to resident #001 provide care to the resident in accordance with the home's training program (related to mechanical lifts, transfers and positioning) and the home's policy titled "Mechanical Lifts Procedure – LP-01-01-03", last updated August 2017.

Grounds / Motifs :

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

A CIS report was submitted to the Director for a fall that occurred in the fall of 2018, which resulted in resident #001 sustaining injuries. The CIS report identified that resident #001 had been sitting up at their bedside when they fell off their bed.

(a) A review of resident #001's care plan in place at the time of the fall, included an intervention initiated in the winter of 2015, which identified the resident was to perform a specific activity of daily living (ADL) while lying down.

During an interview with resident #001 about their fall, they stated that a PSW helped them with an ADL while they sat up on the edge of the bed, then they fell forward off the bed and onto the floor.

During an interview with PSW #119, they stated that they had been with resident #001 during the fall. The PSW stated they went into the resident's room and sat the resident on the side of the bed, with one of their hands holding their bed rail. The PSW stated they had intended to bring a mechanical lift closer to the resident so the resident could hold onto it while seated at the edge of the bed. The PSW stated the resident would hold both the bed rail and mechanical lift while participating in specific ADLs. The PSW stated that the resident's care plan was incorrect when it identified the resident lay in bed to complete and ADL as staff never did that, they had all sat the resident on the edge of their bed when completing the ADLs.

During an interview with PSW #125, they indicated that the mechanical lift should not be used as something for a resident to hold onto when they are seated at the side of their bed. The PSW stated that if residents required care in bed, they were provided with the care while lying down.

During an interview with the DOC, they reviewed resident #001's care plan in place at the time of the fall and indicated that staff should not have sat the resident on the edge of the bed to complete an ADL, that the mechanical lift should not have been used for the resident to hold on to while seated on the bed while care was provided, and that the positioning and use of the lift in that manner was not a safe positioning technique.

(b) A review of resident #001's current care plan identified the resident's bed

height was to be in the low position while the resident was in bed, as a falls related intervention.

A review of the home's policy titled "Mechanical Lift Procedure – LP-01-01-03", last updated August 2017, identified staff were to remain with the resident during the entire time the sling was connected to the mechanical lift.

On a date during the inspection, Inspector #625 observed resident #001 lying in bed in a sling that was connected to a mechanical lift. The bed was elevated and the mechanical lift brakes were unlocked. PSW #125 entered the room after approximately two minutes had passed, saw the Inspector, and then left the room for a second time for approximately another two minutes.

During an interview with resident #001, they indicated that staff usually left the resident unattended and connected to the lift in the manner observed by the Inspector.

During an interview with PSW #125, they stated that they had left resident #001 in the state the Inspector observed to find someone to help transfer the resident.

During an interview with PSW #116, they stated two staff were needed for all transfers (using mechanical lifts) and they had assisted PSW #125 get the sling under resident #001 and then left to help a co-worker. The PSW reviewed resident #001's current care plan that identified the bed was to be in a low position when the resident was in bed, and indicated the height of resident #001's bed when the sling was connected to the mechanical lift was not the low position.

During an interview with the DOC, they indicated that leaving a resident unattended, connected to a mechanical lift via a sling as observed by the Inspector, was not a safe positioning technique, and that leaving resident #001 in a bed not in low position was not in accordance with their care plan and was not a safe positioning technique.

(c) A review of resident #001's current care plan identified the resident required the assistance of two staff to assist with transfers using a mechanical lift, including one staff to support and maneuver parts of the resident's body

throughout the transfer, as well as the RPN or RN to assist as needed.

A review of the home’s policy titled “Mechanical Lift Procedure – LP-01-01-03”, last updated August 2017, identified that, when using a specific type of mechanical lift, a second staff person was required to steady the resident.

On a date during the inspection, Inspector #625 observed PSW #125 and RPN #124 transfer resident #001 from one location to another. The RPN did not physically participate in the transfer. The PSW raised the resident in the lift, pivoted the lift, and lowered the resident. The resident’s specific body parts were not supported and maneuvered by one staff throughout the transfer, and the RPN did not steady the resident during the transfer.

During an interview with the DOC, they stated that two staff were required to operate mechanical lifts in the home. The DOC indicated the staff performing the lift observed by the Inspector did not perform the transfer in accordance with resident #001’s current care plan if the resident’s specific body parts were not supported and maneuvered throughout the transfer, the transfer was not in accordance with the Safe Lifting with Care Program as the second staff person did not steady the resident, and the method of transferring resident #001 observed by the Inspector was not a safe transferring technique.

The decision to issue a CO was based on the severity which indicated actual harm had occurred to the resident. The scope identified the non-compliance in this area was isolated to resident #001. The home does not have a compliance history specific to this area of the legislation. (625)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Sep 03, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of June, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Katherine Barca

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