Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2020	2020_664602_0023	020247-20, 020376-20, 021783-20, 022837-20, 023284-20, 023321-20, 023406-20	Critical Incident System

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 Brockville ON K6V 5T1

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

St. Lawrence Lodge
1803 County Road, #2 East Postal Bag #1130 Brockville ON K6V 5T1

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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 10, 13, 14, 17-20 & 23-27, 2020

The following inspections were conducted:
Log #020247-20/ CIS #M576-000032-20 – regarding a missing controlled substance.
Log #020376-20/ CIS #M576-000033-20 – regarding medication/treatment administration.
Log #021783-20/ CIS #M576-000035-20 – regarding alleged staff to resident neglect.
Log #022837-20/ CIS #M576-000038-20 – regarding a fall with injury requiring hospitalization.
Log #023284-20/ CIS #M576-000043-20 – regarding safe transfers and positioning.
Log #023406-20/ CIS #M576-000045-20 – regarding hospitalization/change in condition.
Log #023321-20/ CIS #M576-000044-20 – regarding medication administration.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Directors of Care (ADOC), the Acting Director of Care (DOC), the Infection Prevention & Control (IPAC) management lead, the RAI coordinator, the Physiotherapist, a pharmacy consultant, residents, family members and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care & progress notes, medication & treatment administration records, relevant policies and procedures, investigation documentation, and made resident care & service and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that medications were administered to two residents in accordance with the directions for use specified by the prescriber.

A resident was prescribed a medicated ointment for a wound. The medicated treatment did not begin until several days after it was ordered. Prior to treatment initiation the wound became infected and required the prescription of an oral antibiotic.

Another resident received a bedtime medication during the morning medication pass. The incident was reported, the resident was assessed and monitored and despite the potential risk to the resident there were no ill effects as a result of the error.

Sources: Critical Incident System (CIS) report, medication administration records, progress notes, medication incident form(s) and interview(s) with the Director of Care (DOC), two Assistant Directors of Care (ADOCs) and other staff. [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The incident was not immediately reported to the resident's Substitute Decision Maker (SDM), the DOC, the Medical Director, the physician or the pharmacy provider resulting in a delay in initiating treatment.

A resident was prescribed a medicated ointment and an order was completed, however the ointment was not received. The subsequent investigation revealed three separate re-order attempts were completed, however, the pharmacy advised the order for the medicated ointment was not received for several days. The treatment began after the wound became infected. An ADOC, the DOC and the resident's SDM were alerted to the incident. A medication incident report was completed two weeks later.

Sources: CIS report, medication incident report, progress notes, medication & treatment administration records; the Medication Reordering policy, the Medication Incident Report policy and interview(s) with the DOC, two ADOCs and other staff. [s. 135. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident .

A resident was assisted to the toilet using a mechanical lift by a Personal Support Worker (PSW). The resident was not positioned properly in the sling nor was the belt secured resulting in the resident slipping and the belt sliding up to the residents neck. There was a significant potential for harm of the resident who may have fallen to the floor or been choked by the belt. The PSW called for assistance and the resident was transferred back to their bed. A review of the licensee's lifting and transferring residents policy indicated that "No employee is to use an electric or mechanical lift alone".

Sources: CIS report, progress notes and plan of care, Lifting and Transferring of Residents policy & procedure and interview(s) with an ADOC, the DOC and other staff. [s. 36.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an alleged incident of neglect of a resident was immediately investigated:

An ADOC was advised by a resident's family that the resident had been left alone on the toilet on a previous evening. The resident required the assistance of one to transfer on and off the toilet. The ADOC commenced an investigation several days later.

Sources: CIS report, progress notes & plan of care and interviews with an ADOC and other staff. [s. 23. (1) (a)]

2. The licensee failed to ensure that appropriate action was taken in response to the alleged incident of neglect.

An ADOC commenced an investigation into an allegation of neglect of a resident . The ADOC reviewed the incident with PSW staff and confirmed that a PSW had placed the resident on the toilet prior to going off unit for their break. The PSW was unable to recall if they had alerted their co-worker(s) that the resident had been left alone and would require assistance to transfer off the toilet. The ADOC advised they had not followed up with resident's SDM regarding their investigation, nor had they reviewed end of shift / pre-break communication requirements with PSW staff. The ADOC further indicated that staff do not consistently communicate this information with each other prior to breaks or change of shift.

Sources: CIS report, resident progress notes & care plan and an interview with the ADOC. [s. 23. (1) (b)]

3. The licensee failed to ensure that the results of the neglect investigation were reported to the Director.

An ADOC investigated an allegation of neglect of a resident. There was no follow-up included on the CIS report. The ADOC indicated they had not reported the results of their investigation or subsequent actions taken, to the Director.

Sources: CIS report and an interview with the ADOC. [s. 23. (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 to ensure that every alleged, suspected or witnessed incident abuse &/or neglect of a resident by the licensee or staff is immediately investigated, that appropriate action is taken in response to every such incident; and the results of the investigation are reported, to be implemented voluntarily.

WN #5: 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 failed to ensure that an alleged incident of neglect was immediately reported to the Director.

A complaint regarding alleged neglect was received by an ADOC. The incident was reported to the Director several days later.

Sources: CIS report and an interview with the ADOC. [s. 24. (1)]

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 alleged incident(s) of neglect will be immediately reported to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

An ADOC reported an alleged incident of neglect to the Director; the name of the staff who left the resident alone on the toilet was not included on the original report or on the requested amendment.

Sources: CIS report, and an interview with the ADOC. [s. 104. (1) 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 to ensure reports to the Director include a description of the individuals involved in the incident, including: names of any staff or other persons who were present at or discovered the incident and an analysis & follow-up action including immediate & long-term actions planned to correct the situation & prevent recurrence, to be implemented voluntarily.

WN #7: 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. (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 failed to ensure that a resident's plan of care set out clear directions to staff and others who provide direct care.

A resident had an un-witnessed fall resulting in an injury requiring hospitalization. A review the resident's care plan in place at the time of their fall indicated the resident was at low risk for falls; this was contrary to multiple assessments completed by the physiotherapist and recent fall risk assessments indicating the resident was a high fall risk.

Sources: CIS report, progress notes and care plans, fall risk assessment tools and interview(s) with the physiotherapist, the RAI Coordinator and other staff. [s. 6. (1) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with; specifically Emergency Drug Box policy.

A pharmacy consultant conducted an audit of the emergency drug box on a resident unit and noted three vials of morphine 15mg/ml were missing; upon investigation, it was found that two of the three vials had been removed for use with a resident and had not yet been replaced. The licensee advised the consultant that an investigation into the remaining vial of missing morphine would be completed. An ADOC completed a CIS report one month later as they had been unsuccessful in locating the missing vial of morphine. During this inspection, a re-investigation was commenced and the missing vial of morphine was tracked. The Clinical Resource Nurse (CRN) explained that the morphine had been administered to a resident and that the confusion was a result of staff failing to follow Emergency Drug Box policy documentation requirements.

Sources: Emergency Drug Box policy, Narcotic Controlled Substance Administration records, Narcotic Controlled Substance Administration record/Emergency Box, and interview(s) with the pharmacy consultant, an ADOC, the CRN and other staff. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after a resident was admitted to hospital for injuries resulting in a significant change in the resident's health status.

A resident was admitted to hospital for post fall fractures resulting in the need for total assistance by staff with activities of daily living. A critical incident report was submitted to the Director by the DOC several days after the admission to hospital.

Sources: CIS report, progress notes & care plans and interview(s) with the DOC and other staff. [s. 107. (3) 4.]

Issued on this 31st day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602)
Inspection No. / No de l'inspection :	2020_664602_0023
Log No. / No de registre :	020247-20, 020376-20, 021783-20, 022837-20, 023284-20, 023321-20, 023406-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 18, 2020
Licensee / Titulaire de permis :	The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott c/o St. Lawrence Lodge, 1803 County Road 2, Brockville, ON, K6V-5T1
LTC Home / Foyer de SLD :	St. Lawrence Lodge 1803 County Road, #2 East, Postal Bag #1130, Brockville, ON, K6V-5T1
	Carolyn Zacharak

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

To The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must comply with s. 131(2) of O. Reg. 79/10.
Specifically, the licensee shall:
1. Ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
2. Complete training specific to the medication ordering/re-ordering process for all registered staff who administer and order/re-order medications.
3. Keep a record of all meetings, training/re-training provided including the dates and the persons who attended.

Grounds / Motifs :

1. The licensee failed to ensure that medications were administered to two residents in accordance with the directions for use specified by the prescriber

A resident was prescribed a medicated ointment for a wound. The medicated treatment did not begin until after the wound became infected. A prescription for an oral antibiotic was required.

A resident received a bedtime medication during the morning medication pass. The incident was reported, the resident was assessed and monitored and despite the potential risk to the resident there were no ill effects as a result of the error.

Sources: CIS report, medication & treatment administration records, progress notes, medication incident form(s) and interview(s) with the DOC, two ADOCs and other staff.

An order was made taking the following factors into account:
Severity: Two residents were not provided their medications as prescribed resulting in actual harm to one resident (wound became infected) and potential for harm to another resident.
Scope: This issue was identified as a pattern as two of the three residents reviewed did not receive their medication as prescribed.
Compliance History: The licensee was previously found to be in non-compliance in the same subsection of the legislation and were issued 2 VPCs in the past 36 months. (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2021

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must comply with s. 135 (1) of O. Reg. 79/10.

Specifically, the licensee shall:

1. Ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health;
2. Complete a review of the medication incident reporting policy including the requirement to document, act on and report medication incidents with all registered staff who administer medications.
3. Keep a record of all meeting(s)/review session(s) provided including the dates and the persons who attended.

Grounds / Motifs :

1. The licensee failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The incident was not immediately reported to the resident's SDM, the DOC, the Medical Director, the physician or the pharmacy provider resulting in a delay in initiating treatment.

A resident was prescribed a medicated ointment and an order was completed, however, the ointment was not received. The subsequent investigation revealed three separate re-order attempts were completed, however the pharmacy advised the order for the medicated ointment was not received. The treatment began after the wound became infected. The ADOC, DOC and the resident's SDM were alerted to the incident and a medication incident report was completed two weeks later.

Sources: CIS report, medication incident report, progress notes, medication & treatment administration records, the Medication Reordering policy, the Medication Incident Report policy and interview(s) with the DOC, two ADOCs and other staff.

An order was made taking the following factors into account:
Scope: This issue was identified as a pattern as there were fourteen identified incidents of missed administration of the resident's medicated ointment.
Severity: The resident was not provided the medicated ointment as prescribed resulting in a wound infection/actual harm.
Compliance History: The licensee was previously found to be in non-compliance in the same subsection of the legislation for which two VPCs were issued in the past 36 months.
(602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

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 O. Reg. 79/10.
Specifically the licensee shall:
1. Ensure the resident is transferred safely on and off the toilet
2. Prior to resuming resident care; the Personal Support Worker (PSW) will complete transfer and positioning re-fresher training including the use of mechanical lifts.
3. Complete weekly audits of lift transfers on each unit until such time that no concerns arise related to the safe transferring of residents; maintain a written record of the audits and any actions taken as a result of the observation(s).

Grounds / Motifs :

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

A resident was assisted to the toilet using a mechanical lift by a PSW. The resident was not positioned properly in the sling nor was the belt secured resulting in the the resident slipping and the belt sliding up to the residents neck. There was significant potential for harm of the resident who may have fallen to the floor or been choked by the belt. The PSW called for assistance and the resident was transferred back to their bed. A review of the licensee's lifting and transferring residents policy indicated that "No employee is to use an electric or mechanical lift alone".

Sources: Critical Incident System (CIS) report, progress notes and plan of care, Lifting and Transferring of Residents policy & procedure and interview(s) with an Assistant Director of Care (ADOC), the Director of Care (DOC) and other staff.

An order was made taking the following factors into account:
Severity: The resident was at potential for significant harm resulting from a possible fall or choking on the sling's belt.
Compliance History: The licensee was previously found to be in non-compliance in the same subsection of the legislation in the past 36 months.
(602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 18th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

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