Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 25, 2024
Inspection Number: 2024-1236-0002
Inspection Type: Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Telfer Place, Paris

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
July 10, 11, 12, and 15, 2024

The following Critical Incident (CI) intakes were inspected:
- Intake #00112143 [CI #2742-000007-24/2742-000010-24] related to improper/incompetent treatment of a resident
- Intake #00113921 [CI #2742-000013-24] related to improper/incompetent treatment of a resident
- Intake #00115897 [CI# 2742-000016-24] related to a COVID Outbreak
- Intake #00119753 [CI #2742-000022-24] related to an Enteric Outbreak

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to shall ensure that a resident exhibiting altered skin integrity received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

Rationale and Summary
A critical incident was reported to the Ministry of Long-Term Care and documented a resident sustained an injury.

The Education Lead verified there was no initial skin and wound assessment and there was no other skin and wound assessment to document that the area of altered skin integrity had healed. There was no documentation of a treatment order for the skin assessment and monitoring of the injury.

The area healed with no negative outcome for the resident.

Sources: resident clinical record review, observations and staff interviews.

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 40
Specifically, the licensee must:
a) Ensure the care plan interventions for two residents are reviewed related to the use of footrests and provide clear directions to staff and others who provide direct care to the residents related to wheelchair mobility. The interventions must identify safety risks and other special needs related to the use of footrests. The care plan must identify the location of the footrests when not in use.
b) Ensure that staff and others use safe transferring and positioning with the use of footrests when assisting a resident with wheelchair mobility.
c) Ensure that staff and others use safe transferring and positioning with the use of footrests when assisting a resident with wheelchair mobility.

Grounds
The licensee failed to ensure that a Personal Support Worker (PSW) used safe positioning devices when assisting two residents with wheelchair mobility.

Rationale and Summary
A) A critical incident was reported to the Ministry of Long-Term Care (MLTC) and documented a PSW offered to transfer a resident by wheelchair, the resident sustained a fall and injury. The home received a written complaint from a staff member that the resident was transported by wheelchair without footrests.

Investigation notes and review of video surveillance identified the resident was transported by wheelchair without footrests. The video showed the PSW did not go to the front of the wheelchair to ensure the footrests were in place, nor did they check to see if the resident's feet were on the footrests.

Wheelchair Safety Fast Facts as part of the education for safety training documented to support the resident's feet and legs to reduce their potential for sliding forward in the chair and footrests must be used at all times when pushing a resident in a wheelchair as there could be a significant risk of injury to the resident and the person pushing the chair. There was a significant impact to the resident's well being as they sustained an injury. The incident could have been prevented if the PSW ensured the use of footrests as a positioning device when assisting the resident with wheelchair mobility.

B) A critical incident was reported to the MLTC and documented the same PSW was witnessed pushing another resident's wheelchair without the use of both footrests.

Investigation notes documented it was confirmed that the resident's wheelchair was being pushed by the PSW and the wheelchair had only one footrest on.

The PSW verified the resident did have both footrests available for use at the time of the incident. There was no negative impact to the resident, however the resident was at risk for harm and injury when the PSW did not ensure the use of the footrest

as a positioning device when assisting the resident with wheelchair mobility.

Sources: investigation notes, resident clinical record review, training materials, observations, and resident and staff interviews.

This order must be complied with by August 16, 2024

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

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

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