Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2017	2016_334565_0012	022452-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION
60 RICHVIEW ROAD ETOBICOKE ON M9A 5E4

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

UKRAINIAN CANADIAN CARE CENTRE
60 RICHVIEW ROAD ETOBICOKE ON M9A 5E4

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

MATTHEW CHIU (565), DEREGE GEDA (645), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 28, 29, Aug 2, 3, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, and 19, 2016.

During the course of the inspection, the following Critical Incident Intakes were inspected:
- 004446-16: related to staff to resident abuse,
- 024595-16: related to resident fall with injury.
During the course of the inspection, the following Complaint Intakes were inspected:
- 028457-15: related to Residents' Bill of Rights,
- 012425-16 and 013694-16: related to staff to resident abuse.
During the course of the inspection, the following Follow Up to Order Intake was inspected:
- 001282-16: related to resident plan of care and safe transferring.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, MDS Coordinator, Documentation Nurse, Infection Control Nurse, Registered Dietitian, Food Services Aides, Social Worker, Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Former Personal Support Worker Student, Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

- **5 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Findings/Faits saillants :

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

Review of the Compliance Order #002 issued under the Resident Quality Inspection (RQI) #2015_413500_0014, revealed that the home had failed to use safe transferring

techniques when assisting a resident. As a result, the resident had sustained an identified significant injury. The order was issued to prepare, submit and implement a plan for achieving compliance with s. 36 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents particularly in respect to managing residents' safety risks and prevention of harm to residents.

During stage one of the RQI, staff interview and record review revealed resident #002 sustained an identified medical condition and was hospitalized.

Review of resident #002's progress notes, plan of care and Resident Assessment Protocol – Minimum Data Set (RAI-MDS) assessment revealed the resident had physical and cognitive impairment. The resident was diagnosed with the identified medical condition on an identified date. The plan of care stated the resident should be transferred or toileted with the specified transferring device and techniques. The PointClickCare (PCC) records revealed the resident was transferred and toileted on an identified date, and they were signed off by Personal Support Worker (PSW) #107.

Interview with PSW #107 revealed during an identified time period on the identified date, he/she transferred the resident not using the specified transferring device but another identified transferring device. The staff member indicated the resident's medical condition had changed over the past several months. The transferring device specified in the plan of care was used for the resident previously. As the resident's condition changed, the staff member started using the identified transferring device that he/she just used. The staff member did not recollect what date it started, and further indicated the resident could perform the identified actions as required by using the identified transferring device that he/she just used. During two subsequent interviews a few days after, PSW #107 told the inspector that he/she made the wrong statement in the first interview. The PSW indicated he/she did not use the identified transferring device to transfer the resident on the identified date. The transferring device indicated in the plan of care was used on that day, and he/she did not toilet the resident during the identified time period on the identified date. The PSW indicated he/she might have made a mistake in recording the resident's toileting.

Interview with PSW #116 revealed he/she usually assisted PSW #107 to transfer resident #002. The PSW further indicated on the identified date, he/she assisted PSW #107 to transfer the resident for toileting using the identified transferring device as mentioned by PSW #107 in his/her first interview.

Interview with a family member indicated due to the resident's identified medical condition, he/she started using the transferring device that specified in the plan of care for several months, and the transfer sign was posted in the resident's room.

Interviews with Registered Practical Nurse (RPN) #108 and the Director of Care (DOC) indicated in an identified period in 2015, the resident's plan of care for transfer was changed to use the specified transferring device. Interviews with the Physiotherapist (PT) and the DOC indicated due to the resident's identified condition, he/she was unable to perform the identified actions required by using the other identified transferring device. Furthermore, it is unsafe for the resident to perform the required identified actions during the transfer. The DOC confirmed the transferring device that mentioned by PSW #116 and #107 during his/her first interview was an unsafe transferring device when assisting the resident. [s. 36.]

2. Review of a Critical Incident System (CIS) report revealed that on an identified date, a former PSW student #118 asked PSW #117 to transfer resident #015. During the transfer, PSW #117 provided an identified improper care to the resident and it resulted in harm to the resident.

Review of resident #015's plan of care and RAI-MDS assessment revealed the resident required a specified transferring device and assistance for transfer.

The home's policy entitled "Minimal Lift Program Procedures for Lifts and Transfers", Policy #RCS 6-8-5, states that "In all situations when a resident requires the use of a mechanical lift for safe transfer, a minimum of two staff members must always be present."

Interview with resident #015 indicated he/she recollects the incident and the specified symptom that resulted from the incident.

Interview with the PSW student and a family member who witnessed the transfer indicated that the transfer was performed by PSW #117 with the presence of the PSW student. During the transfer, an identified event happened and caused the resident's specified symptom.

Interview with PSW #117 indicated he/she could not recall the details of the incident. Interview with RPN #106 indicated when the specified transferring device was used to transfer the resident, it should be performed by at least two staff members in order to

operate the device and transfer the resident safely. The PSW student should not be considered as the second staff member during the transfer.

Interviews with the DOC indicated that a safe transferring technique for using the specified transferring device includes the safe operation of the device by one person who takes lead in the transfer, and the safe maneuver of the device by another person who assists in the transfer.

The DOC confirmed during the above mentioned incident, the maneuver of the device was unsafe, and it resulted in harm to the resident. Furthermore, since only one staff member was present during the transfer, it was an unsafe technique according to the policy of the home.

The severity of the non-compliance and the severity of the harm is actual.

The scope of the non-compliance is isolated to resident #002 and #015.

A review of the Compliance History revealed the following non-compliance related to the O. Reg. 79/10 of the Long-Term Care Homes Act, 2007, r. 36. Transferring and positioning techniques: a Compliance Order was issued under inspection #2015_413500_0014. [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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

During stage one of the RQI, the RAI-MDS assessment and staff interview revealed resident #005 was incontinent and had a fall.

The written plan of care for resident #005 states that the resident is at risk for falls related to his/her identified medical conditions. Review of the written plan of care with an identified revision date documents that the resident requires the specified numbers of staff assistance for toileting. A specified transferring device is an alternative method if the

specified maximum number of staff assistance cannot be performed.

Over the period of August 8-10, 2016, inspector #116 observed a logo posted over resident #005’s bed which indicates the specified numbers of staff assistance or the specified transferring device for toileting and transfers. On August 11, 2016, the logo was updated to reflect the specified maximum number of staff assistance or the specified transferring device for transfer and toileting.

Throughout the inspection period the resident was observed to self transfer with slight difficulty, from bed to chair without assistance on one occasion.

Interviews held with PSW #129, #132 and #137 stated that resident #005 is able to be transferred with the specified minimum number of staff assistance. Staff members stated that they were unaware of any revisions made to the resident's transferring capabilities.

Review of physiotherapy quarterly re-assessment conducted on an identified date revealed and an interview held with the PT confirmed that resident #005 requires the specified transferring device or the specified maximum number of staff assistance for transfers. The PT stated that he/she could not recall whether the revision to resident #005's transferring requirements was communicated to the staff. Interviews held with the PT and the DOC confirmed that the staff did not collaborate in the development and implementation of the plan of care for resident #005’s transferring requirements so that the assessments are integrated, consistent and complement each other. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the Compliance Order #001 issued under the RQI #2015_413500_0014, revealed that care set out in the plan of care was not provided to a resident as specified in the plan of care. As a result, the resident had sustained an identified significant injury. The order was issued to prepare, submit and implement a plan for achieving compliance with s. 6 (7) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During stage one of the RQI, staff interview and record review revealed resident #002 sustained an identified medical condition and was hospitalized.

Review of resident #002’s progress notes, plan of care and RAI-MDS assessment

revealed the resident had physical and cognitive impairment. The resident was diagnosed with the identified medical condition on an identified date. The plan of care stated the resident should be transferred or toileted with the specified transferring device and techniques. The PCC records revealed the resident was transferred and toileted on an identified date, and they were signed off by PSW #107.

Interview with PSW #107 revealed during an identified time period on the identified date, he/she transferred the resident not using the specified transferring device but another identified transferring device. The staff member indicated the resident's medical condition had changed over the past several months. The transferring device specified in the plan of care was used for the resident previously. As the resident's condition changed, the staff member started using the identified transferring device that he/she just used. The staff member did not recollect what date it started, and further indicated the resident could perform the identified actions as required by using the identified transferring device that he/she just used. During two subsequent interviews a few days after, PSW #107 told the inspector that he/she made the wrong statement in the first interview. The PSW indicated he/she did not use the identified transferring device to transfer the resident on the identified date. The transferring device that specified in the plan of care was used on that day, and he/she did not toilet the resident during the identified time period on the identified date. The PSW indicated he/she might have made a mistake in recording the resident's toileting.

Interview with PSW #116 revealed he/she usually assisted PSW #107 to transfer resident #002. The PSW further indicated on the identified date, he/she assisted PSW #107 to transfer the resident for toileting using the identified transferring device as mentioned by PSW #107 in his/her first interview.

The DOC confirmed that the care set out in the plan of care was not provided to the resident when staff transferred the resident for toileting using the identified transferring device instead of the specified device that stated in the plan of care.

The severity of the non-compliance and the severity of the harm is potential for actual harm.

The scope of the non-compliance is isolated to resident #002.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7). Plan of Care. A Written Notification (WN)

and a Voluntary Plan of Correction (VPC) was issued during the inspection # 2014_337581_0024 on December 4, 2014, and a WN and a Compliance Order was issued during the inspection #2015_413500_0014 on September 10, 2015. [s. 6. (7)]

3. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Review of resident #002's progress notes, plan of care and RAI-MDS assessment revealed the resident had physical and cognitive impairment. The plan of care stated the resident should be transferred or toileted with the specified transferring device and techniques.

Interview with PSW #116 revealed he/she usually assisted PSW #107 to transfer resident #002. On an identified date, PSW #116 assisted PSW #107 to transfer the resident for toileting using an identified transferring device. It was not the specified device that stated in the plan of care. PSW #116 further indicated he/she thought the plan of care stated both types of transferring device can be used to transfer the resident.

The staff member confirmed he/she was not aware of the contents of the resident's plan of care which stated the resident cannot be transferred or toileted by the identified transferring device that he/she used on the identified date. [s. 6. (8)]

4. The licensee has failed to ensure that the resident's plan of care is revised when the resident's care set out in the plan is no longer necessary.

Review of resident #002's plan of care and RAI-MDS assessment revealed the resident had physical and cognitive impairment. The plan of care stated the resident has specified diet, and uses an identified assistive device.

Interview with a family member indicated the resident had the identified assistive device when he/she was first admitted to the home and the resident had not been using it for some time. The resident had been provided the specified diet and had not needed to use the assistive device.

Interviews with PSW #107 and RPN #108 indicated the resident had not been using the identified assistive device for a long time. Since the resident had the specified diet, he/she had no need to use the identified assistive device.

Interviews with RPN #108 and the DOC confirmed that the plan of care for the resident #002's identified assistive device use had not been revised as the care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

5. Review of resident #011's plan of care and RAI-MDS assessment revealed the resident had physical and cognitive impairment. The plan of care stated staff to ensure that an identified personal device is clean, appropriate and being used by the resident. The RAI-MDS assessment and the Resident Assessment Protocol (RAP) dated an identified date stated the resident did not use the identified personal device.

On August 10, 2016, the inspector observed the resident wandered in an identified resident home area without using the identified personal device.

Interviews with PSW #111 and RPN #112 revealed the resident used to use the identified personal device and stopped a few months ago as the resident did not want it and took it off. The staff members indicated the resident could perform the identified daily activities by himself/herself, and it was not necessary for him/her to use the identified personal device.

PSW #111, RPN #112 and the DOC confirmed that the resident's plan of care for using the identified personal device was not revised as required. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- The staff and others involved in the different aspects of care of the resident collaborate with each other 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,
- The staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Review of a CIS report revealed that on an identified date, a former PSW student #118 asked PSW #117 to transfer resident #015. During the transfer, PSW #117 provided an identified improper care to the resident and it resulted in harm to the resident.

Review of an identified home's document indicated that PSW #117's behaviour and actions were inappropriate and unacceptable, and the home had taken identified actions towards the staff member.

Interview with resident #015 indicated he/she recollects the incident and the specified symptom that resulted from the incident.

Interview with the PSW student indicated on the identified date when PSW #117 was transferring the resident, an identified event happened and caused the resident's specified symptom. The resident was upset, and PSW #117 responded verbally in a disrespectful manner.

Interview with a family member who witnessed the transfer indicated when PSW #117 was transferring the resident, he/she was rough and pushy. The resident expressed an identified concern, and the PSW responded verbally in a disrespectful manner.

Interview with the DOC confirmed the home had failed to ensure that PSW #117 had fully respect resident #015's right to be treated with courtesy and respect during the above mentioned incident. [s. 3. (1) 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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity are fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of a CIS report revealed that on an identified date, a former PSW student #118 asked PSW #117 to transfer resident #015. During the transfer, PSW #117 provided an identified improper care to the resident and it resulted in harm to the resident.

Review of resident #015's plan of care and RAI-MDS assessment revealed the resident required a specified transferring device and assistance for transfer.

The home's policy entitled "Minimal Lift Program Procedures for Lifts and Transfers", Policy #RCS 6-8-5, states that "In all situations when a resident requires the use of a mechanical lift for safe transfer, a minimum of two staff members must always be present."

Interview with the PSW student and a family member who witnessed the transfer indicated that the transfer was performed by PSW #117 with the presence of the PSW student. During the transfer, an identified event happened and caused the resident's specified symptom.

Interview with PSW #117 indicated he/she could not recall the details of the incident. Interviews with RPN #106 and the DOC confirmed when the specified transferring device was used to transfer the resident, it should be performed by at least two staff members and the PSW student was not a staff member. The DOC further confirmed the home's policy of a minimum of two staff members must always be present during the transfer was not complied with. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) on an identified date related to staff to resident neglect.

Interview with the complainant revealed that the home conducted an investigation in regards to his/her complaints and took an identified action. Since the concern was not resolved, the complainant filed a complaint to the MOHLTC on the identified date.

Record review of the home policy entitled "Dealing with Verbal and Written complaints" states that "For all concerns/complaints, a documented record is to be kept in the home". Records should include the nature of the verbal or written complaints, the date the complaint received, the type of action taken the final resolution, every date on which any response was provided and a description of the response.

Record review of the home's complaints binder for an identified period revealed no record for the above mentioned investigation and complaint.

Interview with the DOC indicated that there was an investigation completed and the home took the identified action subsequently. The DOC confirmed that the home did not have a documented record of the nature of the complaint, the date it was received and the type of action taken involved in resolving and investigating the complaint. [s. 101. (2)]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MATTHEW CHIU (565), DEREGE GEDA (645), SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2016_334565_0012
Log No. / Registre no:	022452-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 30, 2017
Licensee / Titulaire de permis :	ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION 60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4
LTC Home / Foyer de SLD :	UKRAINIAN CANADIAN CARE CENTRE 60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandra Lomaszewycz

To ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_413500_0014, CO #002;

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 shall prepare, submit and implement a plan for the following requirements and identify who will be responsible for completing the tasks.
1. Develop an education plan and provide training to direct care staff including but not limited to when and how to use safe transferring devices or techniques when assisting residents.
2. Develop and implement a process to monitor the staff for the safe use of transferring devices or techniques that is based on an assessment of the residents' care needs.
The plan shall be submitted to matthew.chiu@ontario.ca by February 14, 2017.

Grounds / Motifs :

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

Review of the Compliance Order #002 issued under the Resident Quality Inspection (RQI) #2015_413500_0014, revealed that the home had failed to use safe transferring techniques when assisting a resident. As a result, the resident had sustained an identified significant injury. The order was issued to prepare, submit and implement a plan for achieving compliance with s. 36 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents particularly in respect to managing residents' safety risks and prevention of harm to residents.

Review of a Critical Incident System (CIS) report revealed that on an identified date, a former Personal Support Worker (PSW) student #118 asked PSW #117

to transfer resident #015. During the transfer, PSW #117 provided an identified improper care to the resident and it resulted in harm to the resident.

Review of resident #015's plan of care and Resident Assessment Protocol – Minimum Data Set (RAI-MDS) assessment revealed the resident required a specified transferring device and assistance for transfer.

The home's policy entitled "Minimal Lift Program Procedures for Lifts and Transfers", Policy #RCS 6-8-5, states that "In all situations when a resident requires the use of a mechanical lift for safe transfer, a minimum of two staff members must always be present."

Interview with resident #015 indicated he/she recollects the incident and the specified symptom that resulted from the incident.

Interview with the PSW student and a family member who witnessed the transfer indicated that the transfer was performed by PSW #117 with the presence of the PSW student. During the transfer, an identified event happened and caused the resident's specified symptom.

Interview with PSW #117 indicated he/she could not recall the details of the incident. Interview with Registered Practical Nurse (RPN) #106 indicated when the specified transferring device was used to transfer the resident, it should be performed by at least two staff members in order to operate the device and transfer the resident safely. The PSW student should not be considered as the second staff member during the transfer.

Interviews with the Director of Care (DOC) indicated that a safe transferring technique for using the specified transferring device includes the safe operation of the device by one person who takes lead in the transfer, and the safe maneuver of the device by another person who assists in the transfer.

The DOC confirmed during the above mentioned incident, the maneuver of the device was unsafe, and it resulted in harm to the resident. Furthermore, since only one staff member was present during the transfer, it was an unsafe technique according to the policy of the home. (565)

2. During stage one of the RQI, staff interview and record review revealed resident #002 sustained an identified medical condition and was hospitalized.

Review of resident #002's progress notes, plan of care and RAI-MDS assessment revealed the resident had physical and cognitive impairment. The resident was diagnosed with the identified medical condition on an identified date. The plan of care stated the resident should be transferred or toileted with the specified transferring device and techniques. The PointClickCare (PCC) records revealed the resident was transferred and toileted on an identified date, and they were signed off by PSW #107.

Interview with PSW #107 revealed during an identified time period on the identified date, he/she transferred the resident not using the specified transferring device but another identified transferring device. The staff member indicated the resident's medical condition had changed over the past several months. The transferring device specified in the plan of care was used for the resident previously. As the resident's condition changed, the staff member started using the identified transferring device that he/she just used. The staff member did not recollect what date it started, and further indicated the resident could perform the identified actions as required by using the identified transferring device that he/she just used. During two subsequent interviews a few days after, PSW #107 told the inspector that he/she made the wrong statement in the first interview. The PSW indicated he/she did not use the identified transferring device to transfer the resident on the identified date. The transferring device indicated in the plan of care was used on that day, and he/she did not toilet the resident during the identified time period on the identified date. The PSW indicated he/she might have made a mistake in recording the resident's toileting.

Interview with PSW #116 revealed he/she usually assisted PSW #107 to transfer resident #002. The PSW further indicated on the identified date, he/she assisted PSW #107 to transfer the resident for toileting using the identified transferring device as mentioned by PSW #107 in his/her first interview.

Interview with a family member indicated due to the resident's identified medical condition, he/she started using the transferring device that specified in the plan of care for several months, and the transfer sign was posted in the resident's room.

Interviews with RPN #108 and the DOC indicated in an identified period in 2015, the resident's plan of care for transfer was changed to use the specified

transferring device. Interviews with the Physiotherapist (PT) and the DOC indicated due to the resident's identified condition, he/she was unable to perform the identified actions required by using the other identified transferring device. Furthermore, it is unsafe for the resident to perform the required identified actions during the transfer. The DOC confirmed the transferring device that mentioned by PSW #116 and #107 during his/her first interview was an unsafe transferring device when assisting the resident.

The severity of the non-compliance and the severity of the harm is actual.

The scope of the non-compliance is isolated to resident #002 and #015.

A review of the Compliance History revealed the following non-compliance related to the O. Reg. 79/10 of the Long-Term Care Homes Act, 2007, r. 36. Transferring and positioning techniques: a Compliance Order was issued under inspection #2015_413500_0014. (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_413500_0014, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the transfer device and assistance set out in resident #002's plan of care is provided to the resident as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the Compliance Order #001 issued under the RQI #2015_413500_0014, revealed that care set out in the plan of care was not provided to a resident as specified in the plan of care. As a result, the resident had sustained an identified significant injury. The order was issued to prepare, submit and implement a plan for achieving compliance with s. 6 (7) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During stage one of the RQI, staff interview and record review revealed resident #002 sustained an identified medical condition and was hospitalized.

Review of resident #002's progress notes, plan of care and RAI-MDS assessment revealed the resident had physical and cognitive impairment. The resident was diagnosed with the identified medical condition on an identified date. The plan of care stated the resident should be transferred or toileted with the specified transferring device and techniques. The PCC records revealed the resident was transferred and toileted on an identified date, and they were signed off by PSW #107.

Interview with PSW #107 revealed during an identified time period on the identified date, he/she transferred the resident not using the specified transferring device but another identified transferring device. The staff member indicated the resident's medical condition had changed over the past several months. The transferring device specified in the plan of care was used for the resident previously. As the resident's condition changed, the staff member started using the identified transferring device that he/she just used. The staff member did not recollect what date it started, and further indicated the resident could perform the identified actions as required by using the identified transferring device that he/she just used. During two subsequent interviews a few days after, PSW #107 told the inspector that he/she made the wrong statement in the first interview. The PSW indicated he/she did not use the identified transferring device to transfer the resident on the identified date. The transferring device that specified in the plan of care was used on that day, and he/she did not toilet the resident during the identified time period on the identified date. The PSW indicated he/she might have made a mistake in recording the resident's toileting.

Interview with PSW #116 revealed he/she usually assisted PSW #107 to transfer resident #002. The PSW further indicated on the identified date, he/she assisted PSW #107 to transfer the resident for toileting using the identified transferring device as mentioned by PSW #107 in his/her first interview.

The DOC confirmed that the care set out in the plan of care was not provided to the resident when staff transferred the resident for toileting using the identified transferring device instead of the specified device that stated in the plan of care.

The severity of the non-compliance and the severity of the harm is potential for actual harm.

The scope of the non-compliance is isolated to resident #002.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7). Plan of Care. A Written Notification (WN) and a Voluntary Plan of Correction (VPC) was issued during the inspection # 2014_337581_0024 on December 4, 2014, and a WN and a Compliance Order was issued during the inspection #2015_413500_0014 on September 10, 2015. (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Matthew Chiu

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