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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 10, 2018	2018_632502_0003	003238-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Humber Valley Terrace
95 Humber College Blvd. ETOBICOKE ON M9V 5B5

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

JULIENNE NGONLOGA (502), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 12, 13, 14, 15, 16, 20, 21, 23, 26, 27, 28, March 1, 2, 6, 7, 8, 9 and 12, 2018.

The following intakes were inspected concurrently during this inspection:
- CIS #2716-000001-18 (log #001619-18), CIS #2716-000002-18 (log #001684-18) related to staff to resident abuse,
- CIS #2716-000035-17 (log #024034-17) related to resident-to resident abuse,
- CIS #2716-000017-17 (log #008388-17) related to fall,
- CIS #2716-000040-17 (log #027082-17) CIS #2716-000005-18 (log #02438-18) related to injury, cause unknown,
- Complaint log #024808-17 related to Minimizing of Restraining, Residents' Bill of Rights, Prevention of Abuse and Neglect, and
- Complaint log #026427-17 related to fall.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOCs), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSWs), Dietitians, Dietary Aide, Physiotherapists (PT), Housekeeping, Program Assistant (PA), Receptionist, President of the Resident and Family Councils, Substitute Decision Makers (SDMs), and Residents.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff and resident interactions, observed a resident medication administration, observed infection control staff practices, interviewed the Residents' Council (RC) president, completed a Family Council (FC) questionnaire with the FC president, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

Findings/Faits saillants :

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

During the initial tour of the home, the inspector observed staff #111 and staff #112 carried and moved resident #013 from bed to shower chair. Further observation in the

resident's bedroom revealed a transfer logo above the resident bed that indicated a mechanical lift transfer with the assistance of two person.

Review of resident #013's written plan of care completed on an identified date, indicated that they had a specified medical condition and they require mechanical lift with two person total assistance.

Review of Safe Ambulation Lift and Transfer (SALT) assessment from the home electronic documentation system Point click Care (PCC) completed on an identified date indicated that resident #013 requires assistance from two staff using mechanical lift for all transfers.

In separate interviews, staff #111 and #112 stated that they were aware of resident #013 requiring mechanical lift with two person total assistance during all transfers. Staff # 111 stated that they had transferred the resident manually because the lift was hard on them, as they had a specified medical condition, and it was easy for them to transfer the resident without the mechanical lift. Staff #111 told the DOC during the home's fact findings that the resident cannot bear weight it was comfortable and safe to carry them that way.

Staff #112 stated that staff #111, who was the resident's primary care giver, had called them for assistance and told them that the resident was easy to carry, as they were not heavy. Staff #112 confirmed that they had assisted staff #111 with the transfer of resident #013 without a mechanical lift from bed to shower chair.

In an interview, staff #113 stated staff #111 indicated that it was better for the resident to be transferred manually due to their specific medical condition. Staff #113 stated that PSWs should not change the transfer method based on what they believed it is better for the resident, but should report that to registered nursing staff, who will refer the resident to the SALT team for reassessment.

In an interview, staff #102 acknowledged staff #111 and #112 had not used safe transferring techniques when assisting resident #013. Staff #102 stated that the home's expectation was for staff to follow the transfer logo that was posted in the room and updated as per each resident's plan of care. [s. 36.]

2. Based on the finding of non-compliance for resident #013, two other residents' transfers were observed.

On an identified date and time on an identified spa room the inspector observed staff #144 and #145 transferred resident #020 from wheelchair to shower chair using a sit to stand lift, with the sit to stand sling. The staff placed the sit to stand belt around the resident, secured the resident's legs on the lift foot rest, placed the resident's hands on the handle, and then they pulled the resident up with the lift to a standing position. At approximately 60 degree angle, both staff moved the resident from the wheelchair to the shower chair. Staff #145 assisted resident to sit on the shower chair while staff #144 manipulated the lift.

The observation in the resident's room revealed a transfer logo that indicated Hoyer lift and full sling transfer with two person assistance.

Review of resident #020's written plan of care completed on an identified date revealed specified medical condition. The plan of care indicated resident #020 required full support of two staff to transfer safely.

Review of SALT assessment completed on an identified date indicated that resident #020 required total mechanical lift (Hoyer or ceiling lift) with the assistance of two staff members for all transfers.

In an interview, staff #144 confirmed that they assisted staff #145, (who was the resident's primary care giver), with the transfer of resident #020 using the sit-to-stand mechanical lift from wheelchair to shower chair, and had not realized that it was wrong. They stated that they had not checked the transfer logo before assisting staff #145 to transfer the resident from wheelchair to shower chair and that it was a mistake.

In an interview, staff #145, stated that they had been employed in the home for five months and they were aware that resident #020 required total mechanical lift (Hoyer lift). However, when a resident sits on the wheelchair the practice among staff is to use the sit to stand lift to transfer on and off the toilet or shower chair. Staff #145 indicated that they became aware of that practice during orientation and all PSWs are doing the same.

In an interview, staff #102 stated that staff cannot change the level of assistance needed for transferring a resident (especially from total lift transfer into sit-to stand lift, or without a mechanical lift) unless the resident was assessed by the SALT team. They stated that the home's expectation was for staff to follow the transfer logo posted above each resident's bed and the plan of care. The ADOC acknowledged that staff used unsafe

transferring techniques when they assisted resident #020, as they put the resident at risk of injury and fall. [s. 36.]

3. Review of a specified critical incident system (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date revealed that resident #008 sustained an injury with unknown cause. The CIS indicated that during the home's investigation on an identified date the resident reported that staff #146 hit them.

Review of resident #008's progress notes indicated that:
- on an identified date resident #008 complained of pain with specified symptom,
- the following day, the resident stated they were unable to move. They were transferred to the hospital where x-ray was completed and no injury was identified,
- two days after, the resident continued to complain about pain and was assessed with impaired skin integrity, and specified painful range of motion (ROM). The home's physician ordered a second x-ray.
- seventeen days after, x-ray revealed a specified injury.

Review of resident #008's plan of care revised on an identified date revealed that they required sit to stand lift with total assistance of two staff for all transfers due to specified medical condition and risk of injury.
Review of SALT assessment completed on an identified date revealed that resident #008 requires sit-to-stand lift with total assistance of two staff. Review of the PSW's daily flow sheets for transfer revealed resident #008 was transferred during the personal care with physical assistance of one person on an identified date by staff #146. Further review indicated staff #111, #116 and #145 also transferred the resident with one person physical assist on various dates.

On an identified date and time the inspector met resident #008 in their room. The resident told the inspector that a staff injured them and they are not able to perform certain activities of daily living anymore. When the inspector inquired about what occurred, the resident refused to answer further questions.

In an interview, staff #146 stated that they were aware of resident #008's need for total assistance of two staff with a sit to stand lift, however prior to the specified injury, the resident's transfer needs varied during the day. In a specified time of the day the resident was unable to bear weight; all staff used total mechanical lift (Hoyer lift) to transfer them from bed to wheelchair. When the resident was alert, strong enough and able to bear weight, they sometimes transferred the resident during the personal care alone, without

assistance of another staff, using the pivot techniques.

Staff #146 acknowledged that they had transferred the resident alone using pivot technique on an identified date. Staff #111, #116, and #145 denied transferring the resident without lift and assistance of another person, which contradicted their documentation on the flow sheets.

Interview with staff #102 acknowledged that staff had not used safe transferring techniques when assisting resident #008. [s. 36.]

4. Review of a complaint submitted to the MOHLTC on identified date revealed the complainant suspected that the resident had a fall, but the home told them that resident #014 had sustained an injury from unknown cause, which was also reported as CIS report.

Review of resident #014's progress notes revealed that the resident was transferred to the hospital twice within a specified period of time and was diagnosed with a specified injury.

Review of resident #014's most recent written plan of care revealed a specified diagnosis. According to the written plan of care, the quarterly physiotherapist assessments record, and the SALT assessment record documented in PCC since admission revealed that resident #014 requires a mechanical Hoyer lift for transfer and that the resident's transfer method had not changed since the admission in the home.

In separate interviews, staff #109, #105, and #106 confirmed that they had followed the transfer logo posted in the resident room and had transferred resident #014 side by side on two specified dates.

Staff #105 stated that on a specified date they had transferred resident #014 from bed into the wheelchair with the assistance of the resident's Substitute Decision Maker (SDM). On the same day on a specified time they had transferred the resident from the wheelchair into the bed with assistance of another staff, side by side. Staff #105 further stated that resident #014 was light in weight and able to touch the floor slightly with one leg during the transfer; therefore, they assumed that a side by side transfer was acceptable for the resident.

Staff #106 stated that on an identified date they had transferred resident #014 side by

side from the bed into the wheelchair with assistance of two people.

Staff #105 and #106 indicated that they were part time staff and relied on the transfer logo, posted in resident #014's room, which indicated side by side transfer. They confirmed that they had not reviewed the method of transfer for the resident in their written plan of care in the computer which indicated mechanical lift.

Interview with full time staff #126 revealed resident #014 had been transferred side-by-side with two people according to the transfer logo in place since the admission. Staff #126 indicated that during admission, they were approached by the resident's SDM and demonstrated that the resident can be assisted for certain activities of daily living with side-by-side transfer to and from the wheelchair. They relied solely on the transfer logo posted above resident bed on the wall and were not aware that the written plan of care indicated mechanical lift because they never reviewed it.

Interview with staff #100 and review of the home's investigation record revealed that resident #014's transfer logo posted in their room until the moment of the injury identified above, indicated a transfer with assistance of two people, side by side. The transfer logo did not indicate staff to use a mechanical lift for transfer as per the written plan of care. Two registered staff who were part of the SALT team were disciplined for not placing the right transfer logo for resident #014, during the reassessment of the transfer. The home's investigation indicated that when they reviewed resident #014's method of transfer on a specified date they relied on staff saying that resident #014's transfer status has not changed and left the same logo which indicated side-by-side in resident room without checking the clinical record.

Inspector tried to interview the resident but they were not able to talk.

A review of the clinical record, the transfer assessments, interviews with staff #100, #101, #105, #106 and #109 and the home's investigation record confirmed that resident #014 was not safely transferred using a mechanical lift according to the SALT team assessment. [s. 36.]

5. Review of CIS submitted to MOHLTC on a specified date, revealed that resident #011 was transferred to hospital for pain and was diagnosed with an injury.

A review of the progress notes revealed that in the evening of a specified date resident #011 had specified pain and was transferred to the hospital, was diagnosed with an injury

and required surgery.

A review of resident #011's written plan of care revealed the resident transfer status was with sit-to-stand lift, with two person assistance.

Interview with agency staff #130 who monitored resident #011 closely stated that on a specified date the resident appeared to have enough strength and they had transferred the resident side-by-side from the bed to the wheelchair, from the wheelchair to the shower chair, and / or from the shower chair to the wheelchair, on multiple occasions during the shift with the assistance of staff #132 and #133. Staff #130 stated that they were aware of the transfer logo in the room that indicated sit-to-stand lift.

In an interview, staff #133 stated that on an identified date, they had transferred resident #011 between surfaces using the sit-to-stand lift during their shift. However, staff #133 denied transferring the resident side by side, which contradicted their documentation on the flow sheets that the support provided during the transfer was one person.

During the period of inspection, staff #132 revealed they changed the method of transfer from sit-to-stand to Hoyer Lift using a hygienic sling for resident #011 because they wanted to be toileted. Staff #132 was not able to explain what the process for reassessment referral was when the transfer status changes for toileting. Further the staff was not able to confirm if they were provided training in using a hygienic sling with the Hoyer lift, and there was no documentation that resident #011 was reassessed for using the hygienic sling with the Hoyer lift.

Interview with staff #100 indicated that the staff who transferred resident #011 on the specified date, should not have transferred the resident pivot side-by-side. Staff #100 acknowledged that PSWs had not transferred resident #008 safely, as they had not used sit-to-stand lift indicated in the resident's written plan of care, and when PSWs changed the transfer status to Hoyer lift with hygienic sling for toileting the resident was not reassessed. [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. 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to live in a safe and clean environment was fully respected and promoted.

Resident #004 triggered from stage one of the Resident Quality Inspection (RQI) for not being treated with respect and dignity. On an identified date resident #004 told the inspector that staff #116 always stored a garbage bag full with soiled continence care products outside their bedroom. The resident reported that the offensive odour bothered them affecting their sleep, and they had reported that to the registered staff.

On an identified date and time on a specified unit the inspector observed the garbage bag containing soiled continence care products stored opposite an identified room. An offensive odour was noted inside resident #004's bedroom. Observation of the surrounding area revealed residents #015 and #016 were sitting beside the garbage bag identified above. Both residents told the inspector that the offensive odour bothered them, but they got used to it, as it has been an ongoing issue depending on the staff working. This was brought to DOC's attention, and they directed staff to move the identified garbage bag away from the residents.

Review of the home video recording revealed that on specified dates and time staff #135 was observed storing the identified garbage bag with soiled continence care products on the hallway by resident #004's door on multiple occasions.

Review of resident assessment instrument minimum data set (RAI-MDS) assessment completed on an identified date revealed resident #004 had mild cognitive impairment. They are able to speak clearly, communicate in English, and recall things. Resident #004 had not been assessed as having responsive behavior.

In separate interviews, staff #116, #139, and #138 confirmed that resident #004 had complained about offensive odour from the garbage bag stored close to their room at an identified period of time. The staff stated that all staff avoid storing the garbage bag with soiled continence product close to the resident's door, which contradicted the above video recording.

Staff #116 stated it is an ongoing complaint and everyone was aware of it the complaint and had been reported to the management team and that have been going on for at least a year. Now when the resident complained about the smelly garbage bag , they just ignore the resident, as they believed it was their behaviour.

In an interview, staff #102 acknowledged that placing the garbage bag with soiled continence product does not respect resident right to live in a safe environment. [s. 3. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to live in a safe and clean environment was fully respected and promoted, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of a complaint submitted to the MOHLTC on a specified date, revealed that resident #012 had missed an appointment with a specialist at external clinic related to their specific disease.

A review of the discharge instructions from the clinic on a specified date, revealed resident #012's follow up appointment with the specialist was to be booked in two weeks.

In an interview, staff #100 indicated that the resident returned to the home from the external clinic appointment with instructions for a follow up appointment in one month. This was marked in the appointment book/calendar, because the resident's blood work had to be done and sent to the clinic one week before each appointment. According to the home's investigation notes, the clinic had changed the appointment date for one month earlier than originally booked, and faxed the instructions to the home. The fax

letter with the resident's follow-up appointment date was placed in the resident's chart by an unidentified staff member and the appointment book reminder for staff on the unit was not updated with the new date.

Staff #100 acknowledged that resident #012 missed the follow up appointment on the specific date, as the staff who retrieved the fax with the new appointment date had not communicated with other staff in the unit. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of a complaint submitted to the MOHLTC on a specified date, revealed the complainant reported that the home's registered dietitian (RD) and physician (MD) made the decision for resident #012 to have a regular diet instead of a specific diet, as the resident loves their food.

Review of nutritional assessment record on PCC revealed that on a specified date, staff #141 assessed the resident and documented that resident #012's laboratory results continued to worsen, the resident may benefit from a specific diet and planned to discuss the outcome of their assessment and the need to implement the specific diet with the home's physician.

In an interview, staff #141 stated that on a specified date, they had a discussion with the home's physician related to resident #012 diet order as their specific disease worsened. Both the RD and MD agreed that although the resident had the specific health condition, they will continue to provide a regular diet to resident #012 to maintain the quality of life. Both RD and MD planned to discuss with the resident's SDM during the care conference that was scheduled one month later, but the care conference was rescheduled for two months later. After the care conference, the home continued to provide regular diet to maintain resident quality of life.

Staff #141 stated that during the care conference the resident's SDM was informed and they were in favor of liberal diet, as the resident's specific health condition had declined, however, the resident's SDM was upset as they had not been informed about the option of specified diet after the nutritional assessment, which was 65 days before the care conference.

In an interview, staff #102 acknowledged that the resident's SDM should have been notified of the outcome of the nutritional assessment and given opportunity to participate in the decision prior to liberalizing the diet. [s. 6. (5)]

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

Resident #006 triggered for unplanned weight loss from census review during stage one of the RQI.

Review of physician orders revealed that on a specified date, resident #006 had been ordered specific amount of a nutritional supplement. Review of the electronic medication administration record (eMAR) for a specific month, revealed that the nutritional supplement was discontinued the next day once ordered. Review of eMAR for two months later revealed that the nutritional supplement was reinstated two months later.

Review of resident's #006 weight history revealed that they had a significant weight loss in the period when the nutritional supplement was ordered, discontinued and reinstated. Once the supplement was reinstated resident #006 had a weight gain after the nutritional supplement was reinstated.

According to the home's investigation and in an interview with staff #142, the pharmacy had discontinued resident #006's nutritional supplement by mistake on the same month when ordered and the mistake was not captured until the next nutritional quarterly assessment. Staff #142 stated that, resident #006 had not met their daily nutrition requirement during the period identified above as evidenced by not receiving certain calories and proteins per day and losing weight during the same period of time.

In separate interviews, staff #115, #142, and #143 confirmed that nutritional supplement had not been provided to resident #006 in the period of approximately two months as specified in the care plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, and
- the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On a specified date a critical incident system (CIS) report was submitted to MOHLTC related to an alleged resident to resident abuse.

Review of the CIS and the home's investigation notes revealed that on a specified date staff #134 witnessed resident #017 abusing resident #018 while sitting in a common area.

Review of the home's video recording revealed that on the specific date, four residents were sitting in the common area and six other residents in the surrounding area of the

nursing station. During 14 minutes resident #017 had abused resident #018. Two staff members were observed passing by the residents and did not seem to acknowledge the residents until staff #134 arrived at the nursing station and noted the ongoing abuse and intervened.

Review of resident #018's MDS assessment from a specified date, and medical chart revealed that resident #018 had severe memory impairment and depends totally on staff.

Review of resident #017's MDS from a specified date, revealed that resident #017 was admitted several months ago, they are modified independent but had difficulties in challenging situations. Review of resident #017's medical record revealed that the resident had not exhibited an abuse toward any resident prior to and since their admission in the home.

In an interview, resident #017 acknowledged the above incident, told the inspector that the incident was in the past and they did not want to talk about it, if they inspector want to put them in jail, to go ahead.

In separate interviews, staffs #127, #136 told the inspector that resident #017 had not exhibited inappropriate sexual behavior prior to the specific incident and that they had not noticed the alleged abuse when they walked by the residents seated in the common area.

In interview, staff #134 confirmed that they had observed resident #017 abusing resident #018. Staff #134 stated that resident #017 appeared to be ashamed when they intervened and denied doing anything.

In an interview staff #102 stated that the residents are placed in a common area to be monitored closely, and the home's expectation was for staff to visualize/eye-ball the residents each time they passed by. They are also expected to identify any risk and acknowledge or assist the residents that are in need for assistance.

In an interview, staff #100 acknowledged that the incident of alleged abused did occur, and that resident #018 was not protected from abuse from resident #017. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #5: 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 the long term care home had in place, or instituted a plan, policy, protocol, procedure, strategy or system that was in compliance with and is implemented in accordance with all applicable requirements under the Act.

According to O.Reg. 79/10, s. 30.(1) every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A review of the home's policy Safe Resident Handling, Assessment for Lifts and Transfers, CARE6-010.03, dated August 31, 2016, revealed a resident assessment of

needs related to mobility, transferring or lifting will be completed within 72 hours by two SALT team members. The results of the assessment will be discussed with the Charge Nurse for the resident's pan of care/updating. At least on a quarterly basis or as status changes, each resident shall be reassessed for mobility, transferring or lifting needs. If there is significant status change when return from a hospital the resident will be fully reassessed. This assignment is assigned to a SALT team member and is documented on the Assessment Form for Lifts and Transfers. The following physical/visual/verbal risk assessment checks will be completed before all residents handling procedures to ensure that task is safe to complete:
- Communication: is the resident able to make eye contact if required, able to follow simple commands;
- Ability: has there been a change in the resident's physical ability or energy level? Can the resident move their arms/legs if required? Is the resident drowsy?
- Resistance: Is the resident refusing to participate? Are there signs of escalating behaviour? Is the resident agitated or uncooperative?
- Equipment/environment: Are there any obstacles along the path? Is it the correct sling type/styles? Is bed, equipment, or chair positioned properly?

A review of the Assessment Form for Lifts and Transfer contains a section to indicate: if the resident is able to fully weight bear, if the resident is able to partially weight bear, if the resident can help physically, if the resident is able to cooperate, follow instruction, if the resident has consistent behaviours and physical strength, if the resident has pain, what is the condition of the skin, if the resident require assistive aids, and what are the relative mental, medical, physical factors for lifts and transfers. The form further lists the methods of transfer such as: unsupervised, one person supervised, one person minimal assistance, one person assist with transfer belt, two person side by side with transfer belt, mechanical sit/stand lift, mechanical lift.

The safe ambulation lift transfer (SALT) assessment of resident #021 admitted during the inspection was observed. Review of the hospital minimum data set home care (MDS-HC) completed on a specified date, revealed that resident #021 had a health condition that required two person assistance with Hoyer lift from bed to wheelchair. The resident presents with moderate communication status and occasional vision problems.

On a specified date, inspectors #502 and #210 observed a SALT assessment conducted by a SALT team member staff #122, in presence of staff #126 and #147. Resident #021 was observed to have specified medical condition. The family showed a picture to the staff how the resident was transferred using the Hoyer lift in the hospital.

Staff #122 assisted the resident from laying to sitting position, and then move to the edge of the bed. The staff started to assess the resident for a sit-to-stand lift because the family stated they wanted the resident to be toileted. The belt was applied on resident's waist and staff started operating the lift to sit up the resident. The resident was weight bearing on one leg only and they were able to grab and hold on the lift handle with one hand only. While standing on 45 degree angle the staff pushed the resident and transferred them to the wheelchair. After the assessment, staff #122 stated that resident transfer mode would be changed from Hoyer lift to sit-to-stand lift, as resident #021 wants to use the toilet.

A review of the transfer policy did not indicate how the SALT team was to assess the resident when they need to be toileted using the sit-to-stand or Hoyer lift with hygienic sling, such as the range of motion (ROM), and their strength.

The resident's range of motion was not assessed, the different type and size of slings were not assessed, and staff did not consider assessing the resident for a Hoyer lift and hygienic sling for toileting.

An interview with the Educator revealed the nursing and personal care staff are provided training in safe ambulation lift transfer (SALT) once a year and there is a skills check-off list. The staff would demonstrate safe transferring techniques for different types of transfer and use of mechanical lifts. The Educator indicated the check off list is not for PSWs to be trained in deciding the level/method of transfer but to demonstrate the proper transferring techniques. The Educator indicated that the expectation is if there is a health status change of a resident, they have to send referral to the SALT team to assess the resident for appropriate transfer and that there is a SALT representative on every unit and shift.

As the inspectors identified a potential risk of injury to the resident, they questioned staff whether it was safe to change the transfer status from Hoyer lift (as per the hospital assessment) into sit-to-stand lift, based on the fact that the resident wanted to be toileted. The registered staff that initially placed the transfer logo on the wall for Hoyer lift, decided to keep the transfer method with Hoyer lift until a physiotherapy assessment is completed in the home. The resident transferred mode remained Hoyer lift.

According to DOC if there is a change in the health status of a resident staff has to go one level up with the transfer if the present logo is not considered safe until further

assessment.

Interviews with staff #105 and #106 revealed they were able to identify that if a resident is not able to participate and follow instructions, and not able to hold the handles of a sit to stand lift, they are not eligible for sit to stand lift. They were not able to demonstrate that if the resident was not able to participate and follow instructions during the transfer. The method for transfer should have been upgraded to higher level such as total transfer with a mechanical lift. They both transferred resident #014 with the side-by side method without a belt on two specified dates, even though the resident was not able to follow instructions nor was the resident able to actively participate in the side-by side transfer.

A review of the skills check-off sheet for two person side by side transfer with belt revealed assistive device may include transfer/ambulation belt. The procedure that is explained in the check-off sheet is applicable when using a belt. The supportive information indicates the resident should be cooperative and exhibit fairly predictable performance. Interview with PSW # 106 revealed that they interpret the word cooperative as meaning the resident is not resistive during transfer and if they do not do anything or react which means they can proceed with the transfer. Interview with staff #105 indicated that if they are not sure how to transfer the resident they ask the nurse or check the care plan.

A review of the mechanical sit/stand transfer check list that is used for training purposes when staff demonstrates knowledge for transfer revealed a resident is to be transferred with this lift if the resident is able to minimally weight bear on one leg, has adequate strength in upper extremities, must be compliant and able to understand and respond to instructions. Two care givers are required. The manufacturing instructions for the sit-stand lift explains that the resident must be able to weight bear in at least one leg, the resident is also required to have body trunk stability. Before attempting to use Sara 3000, a full clinical assessment of the resident his/her condition, and suitability must be carried out by a qualified person.

The DOC, the Educator and ED were not able to explain the criteria for determining when staff are to use a belt during side-by-side transfer. They were not able to indicate if the check off list for different methods of transfer are to be used for the SALT team or the care providers in the decision of transfer.

A review of the quarterly physiotherapist assessments for resident #014 for a specified period revealed they included the method of transfer in their assessments as being

transferred by mechanical lift. The DOC indicated that the physiotherapist is not part of the SALT team. The MDS assessment for resident #014 indicated the resident had been transferred with mechanical lift for three years. Interview with staff #131 indicated resident #014's transfer status was side-to-side and the logo in the room indicated the same transfer method since admission of the resident.

Interview with staff #132 revealed she started using the hygienic sling with a Hoyer lift for resident #011 because the resident wanted to be toileted. Resident #011's clinical record indicated they sustained an injury on a specified date and had a surgery. According to the written plan of care the continence interventions of resident #011 after the surgery included the incontinent product to be changed as needed. staff #132 was not able to recall if they were provided training in using a hygienic sling with the Hoyer lift, who reassessed resident #011 for using the hygienic sling with the Hoyer lift and what was the process for reassessment referral when the transfer status changes for toileting.

The assessment form for lifts and transfers listed 12 questions about the status of a resident and eight transfer methods but there was no specific criteria/protocol for staff to determine the right transfer. The education material for the mandatory safe transfers training indicated staff to use higher level of transfer if they determine risk or health status change, but this was not identified in the policy.

Interviews with staff #101, #100 and the nurse Educator revealed the Safe Transferring policy did not identify how to achieve an interdisciplinary approach/protocol during the transfer assessment. [s. 8. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to pain was based on an interdisciplinary assessment with respect to the resident's health conditions including pain.

Review of a complaint submitted to the MOHLTC on a specified date, revealed the complainant suspected that the resident had a fall, but the home told them that resident #014 had sustained an injury from unknown cause, which was also reported under a CIS report.

Review of resident #014's progress notes revealed that the resident was transferred to the hospital twice within a specified period of time and was admitted to hospital because of requirement for further treatment. The resident's SDM presented pictures to the home as evidence of resident #014's skin impairment.

Review of two quarterly RAI-MDS quarterly assessments and pain assessments during the same period, revealed that resident #014 did not have a history of pain.

Review of resident #014's most recent written plan of care revealed that their diagnosis affected the activity of daily living (ADL) and weakness. According to the plan of care under the focus of chronic pain related to the related diagnoses, the pain will be at a tolerable level through to the next review. Staff to monitor for non-verbal signs of pain and follow up. Notify physician (MD) and nurse practitioner (NP) of any new/changes in pain status.

According to the plan of care, the resident requires support for communication because of the diagnoses and language barrier. The resident uses sounds to communicate, staff to use signs as much as possible.

Interview with staff #106 revealed they provided care and transferred resident #014 on a specific date in morning from the bed to the wheelchair. According to the PSW, when they arrived in the room the resident was lying in bed on their left side. When staff tried to turn them on the right side, the resident resisted the turning and appeared to be in discomfort or pain. Staff #106 asked if they were ok, the resident did not respond and the PSW proceeded with the transfer, as they were not aware that resident #104 had communication barrier. Staff #106 indicated that they had not reviewed the written plan of care in the computer prior to providing care to resident #014 for the first time that morning. Staff #106 also stated that they had received a report from another staff that the resident should be up in wheelchair for breakfast and no other direction. They confirmed

that they had not reported to the Registered Nurse that the resident seemed to be in pain.

In an interview, night shift staff #114 stated that resident #014 usually was making grimaces like they were in discomfort or pain when they were turned towards their right side to be changed in bed at night. Staff #114 noticed that the discomfort was coming from a particular body part and they were placing a cushion under the body part for a support. Staff #114 confirmed that they had not reported this facial expression to registered staff because that had become usual for the resident and not new in nature and assumed that they knew about the pain. They used the cushion when providing care at night and it was not documented in the written plan of care.
Neither staff #106 nor staff #114 reported the pain to registered staff in order to be assessed and managed.

Interviews with staff #101 indicated when a resident presents with signs and symptoms of pain (such as facial grimacing), or it is a new pain not identified in the written plan of care (such as pain during turning and repositioning) the expectation was for PSWs to report to registered staff for further assessment (such as 72 hours pain monitoring) and pain management. This was not done for resident #014 when they presented with signs and symptoms of discomfort. The resident was not assessed for pain (level of pain, location, duration, causal factors) and there were no strategies for management of the pain. [s. 26. (3) 10.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent and has been assessed as being potentially continent or continent some of the time, receives the assistance and support from staff to become continent or continent some of the time.

A review of the quarterly RAI-MDS assessment revealed that resident #009 was assessed as being incontinent on identified dates and frequently incontinent three months later.

A review of resident #009's written plan of care revealed the resident was at medium risk for falls due to their medical contention. The resident was on a scheduled toileting program.

A review of the flow sheet tasks revealed the resident to be provided assistance with toileting three times during an identified shift.

In an interview, staff #106 revealed they had not toileted resident #009 on a specified day and time. They acknowledged that resident #009 was at risk for falls, and had an unsteady gait. Staff #106 stated that staff became aware of resident #009's need to be toileted when the resident tried to get up and walk. Staff #106 indicated that was their first time working on the specified floor unit. PSW #106 stated that they did not have time to review the resident's plan of care and the flow sheets prior to providing care to the resident.

Interview with staff #122 revealed that residents who are on a toileting routine should be toileted at least every two hours.

Interview with staff #123 revealed they were not aware that the resident was on the resident on the toileting routine.

Interview with staff #129, whose responsibility included updating the care plans, indicated that the home's expectation was for the residents, who are on restorative toileting plan, to be provided assistance with toileting every two hours. They also indicated that the list of the residents on a toileting routine are posted on each unit, and questioned why the flow sheets indicated toileting every three hours instead of two hours. [s. 51. (2) (d)]

WN #8: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible.

Resident #004 triggered from stage one of the RQI for not being treated with respect and dignity. On an identified date, resident #004 told the inspector that staff #116 always placed a garbage bag with soiled care products that smell outside their room. The resident reported that the offensive odour bothered them, affecting their sleep, and they had reported the concern to the registered staff.

On an identified date and time on a specified floor the inspector observed the garbage bag with soiled care products that smell stored opposite a specified room. An offensive odour was noted while inside resident #004's bedroom. Observation of the surroundings revealed residents #015 and #016 were sitting beside the garbage bag identified above. Both residents told the inspector that the offensive odour bothered them, but they got used to that as it has been an ongoing issue depending on the staff working. This was brought to DOC's attention, who directed staff to move the garbage bag away from the residents.

Review of the home complaint's binder revealed a Client Service Response Form (CSRF) had not been completed when resident #004 complained to the staff of the home.

Review of the home's video recording revealed that on identified dates staff #137 and #116 placed the specified equipment with soiled care products in the hallway close to resident's #004's door.

In separate interviews, staff #116, #139, and #138 confirmed that resident #004 had complained about offensive odour from the garbage bag stored close to their room at specified period of time. The staff stated they avoid storing the garbage bag with soiled care products close to the resident's door, which was contradicted in the video recording identified above.

Staff #116 stated that the resident concern was an ongoing complaint, everyone was aware of the complaint, it had been reported to the management team, and had been going on for at least a year. Now when the resident complained about the smelly the garbage bag they just ignore them, as they believed it was their behaviour.

In an interview, staff #138 stated that resident #004 had told them about the smell from the garbage bag at specified time. Staff #138 stated that they checked and the specified garbage bag was away from the resident's room. They stated that they had not informed the on-call manager and the DOC, and had not completed the CSRF.

In an interview staff #102 stated that they were not aware of the resident complaint about the smelling garbage bag. However, they stated that the home's expectation was to complete a CSRF when the resident complained, investigate and inform the management team. [s. 101. (1) 1.]

Issued on this 3rd day of May, 2018

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) :	JULIENNE NGONLOGA (502), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2018_632502_0003
Log No. / No de registre :	003238-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 10, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Humber Valley Terrace 95 Humber College Blvd., ETOBICOKE, ON, M9V-5B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marjorie Mossman

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.36. Specifically, the licensee will ensure staff use safe transferring and positioning devices or techniques when assisting residents #008, #011, #013, #014 #020, #021 and any other resident requiring transfer with a mechanical lifting device.

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents who are required to be transferred with a mechanical device. The plan will include at a minimum, the following elements:

1. Re-assess and document in collaboration with the physiotherapist of residents #008, #011, #013, #014 #020 and #021 and any other resident requiring the use of a mechanical lift for transfer,

2. Review and revise the plans of care for those residents requiring the use of a mechanical lift to ensure that all plans are up to date to accurately direct staff which lift to use at all times including ensuring the lift logos at the bedside are current,

3. Develop and implement a system to randomly audit resident transfer practices to ensure that:
- the staff are compliant with the home's transfer and lifts policies and with residents' individualized plan of care
- proper transfer techniques when using lifts,

4. Review and revise the fall prevention program, specifically policy and procedures of the Safe Ambulation Lift and Transfer (SALT) program, including

the roles and responsibilities of all team members during assessment, referral and transfer,

5. Review and revise the education material, and re-educate all direct care staff to include:
- the types of lifts and slings used in the home for transferring residents,
- the eligibility criteria for the use of each lift and sling,
- the manner in which identified transfer methods are to be used to ensure resident safety.

For all the above, as well as for any other elements included in the plan, please include who will be responsible, a timeline for achieving compliance for each part of the plan and keep the documentation in the home.

The plan should be submitted by April 20, 2018, via email to TorontoSAO.moh@ontario.ca

Grounds / Motifs :

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

Review of CIS submitted to MOHLTC on a specified date, revealed that resident #011 was transferred to hospital for pain and was diagnosed with an injury.

A review of the progress notes revealed that in the evening of a specified date resident #011 had specified pain and was transferred to the hospital, was diagnosed with an injury and required surgery.

A review of resident #011's written plan of care revealed the resident transfer status was with sit-to-stand lift, with two person assistance.

Interview with agency staff #130 who monitored resident #011 closely stated that on a specified date the resident appeared to have enough strength and they had transferred the resident side-by-side from the bed to the wheelchair, from the wheelchair to the shower chair, and / or from the shower chair to the wheelchair, on multiple occasions during the shift with the assistance of staff #132 and #133. Staff #130 stated that they were aware of the transfer logo in the room that indicated sit-to-stand lift.

In an interview, staff #133 stated that on an identified date, they had transferred resident #011 between surfaces using the sit-to-stand lift during their shift. However, staff #133 denied transferring the resident side by side, which contradicted their documentation on the flow sheets that the support provided during the transfer was one person.

During the period of inspection, staff #132 revealed they changed the method of transfer from sit-to-stand to Hoyer Lift using a hygienic sling for resident #011 because they wanted to be toileted. Staff #132 was not able to explain what the process for reassessment referral was when the transfer status changes for toileting. Further the staff was not able to confirm if they were provided training in using a hygienic sling with the Hoyer lift, and there was no documentation that resident #011 was reassessed for using the hygienic sling with the Hoyer lift.

Interview with staff #100 indicated that the staff who transferred resident #011 on the specified date, should not have transferred the resident pivot side-by-side. Staff #100 acknowledged that PSWs had not transferred resident #008 safely, as they had not used sit-to-stand lift indicated in the resident's written plan of care, and when PSWs changed the transfer status to Hoyer lift with hygienic sling for toileting the resident was not reassessed. (210)

2. Review of a complaint submitted to the MOHLTC on identified date revealed the complainant suspected that the resident had a fall, but the home told them that resident #014 had sustained an injury from unknown cause, which was also reported as CIS report.

Review of resident #014's progress notes revealed that the resident was transferred to the hospital twice within a specified period of time and was diagnosed with a specified injury.

Review of resident #014's most recent written plan of care revealed a specified diagnosis. According to the written plan of care, the quarterly physiotherapist assessments record, and the SALT assessment record documented in PCC since admission revealed that resident #014 requires a mechanical Hoyer lift for transfer and that the resident's transfer method had not changed since the admission in the home.

In separate interviews, staff #109, #105, and #106 confirmed that they had followed the transfer logo posted in the resident room and had transferred

resident #014 side by side on two specified dates.

Staff #105 stated that on a specified date they had transferred resident #014 from bed into the wheelchair with the assistance of the resident's Substitute Decision Maker (SDM). On the same day on a specified time they had transferred the resident from the wheelchair into the bed with assistance of another staff, side by side. Staff #105 further stated that resident #014 was light in weight and able to touch the floor slightly with one leg during the transfer; therefore, they assumed that a side by side transfer was acceptable for the resident.

Staff #106 stated that on an identified date they had transferred resident #014 side by side from the bed into the wheelchair with assistance of two people.

Staff #105 and #106 indicated that they were part time staff and relied on the transfer logo, posted in resident #014's room, which indicated side by side transfer. They confirmed that they had not reviewed the method of transfer for the resident in their written plan of care in the computer which indicated mechanical lift.

Interview with full time staff #126 revealed resident #014 had been transferred side-by-side with two people according to the transfer logo in place since the admission. Staff #126 indicated that during admission, they were approached by the resident's SDM and demonstrated that the resident can be assisted for certain activities of daily living with side-by-side transfer to and from the wheelchair. They relied solely on the transfer logo posted above resident bed on the wall and were not aware that the written plan of care indicated mechanical lift because they never reviewed it.

Interview with staff #100 and review of the home's investigation record revealed that resident #014's transfer logo posted in their room until the moment of the injury identified above, indicated a transfer with assistance of two people, side by side. The transfer logo did not indicate staff to use a mechanical lift for transfer as per the written plan of care. Two registered staff who were part of the SALT team were disciplined for not placing the right transfer logo for resident #014, during the reassessment of the transfer. The home's investigation indicated that when they reviewed resident #014's method of transfer on a specified date they relied on staff saying that resident #014's transfer status has not changed and left the same logo which indicated side-by-side in resident

room without checking the clinical record.

Inspector tried to interview the resident but they were not able to talk.

A review of the clinical record, the transfer assessments, interviews with staff #100, #101, #105, #106 and #109 and the home's investigation record confirmed that resident #014 was not safely transferred using a mechanical lift according to the SALT team assessment. (210)

3. Review of a specified critical incident system (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date revealed that resident #008 sustained an injury with unknown cause. The CIS indicated that during the home's investigation on an identified date the resident reported that staff #146 hit them.

Review of resident #008's progress notes indicated that:
- on an identified date resident #008 complained of pain with specified symptom,
- the following day, the resident stated they were unable to move. They were transferred to the hospital where x-ray was completed and no injury was identified,
- two days after, the resident continued to complain about pain and was assessed with impaired skin integrity, and specified painful range of motion (ROM). The home's physician ordered a second x-ray.
- seventeen days after, x-ray revealed a specified injury.

Review of resident #008's plan of care revised on an identified date revealed that they required sit to stand lift with total assistance of two staff for all transfers due to specified medical condition and risk of injury.
Review of SALT assessment completed on an identified date revealed that resident #008 requires sit-to-stand lift with total assistance of two staff. Review of the PSW's daily flow sheets for transfer revealed resident #008 was transferred during the personal care with physical assistance of one person on an identified date by staff #146. Further review indicated staff #111, #116 and #145 also transferred the resident with one person physical assist on various dates.

On an identified date and time the inspector met resident #008 in their room. The resident told the inspector that a staff injured them and they are not able to perform certain activities of daily living anymore. When the inspector inquired

about what occurred, the resident refused to answer further questions.

In an interview, staff #146 stated that they were aware of resident #008's need for total assistance of two staff with a sit to stand lift, however prior to the specified injury, the resident's transfer needs varied during the day. In a specified time of the day the resident was unable to bear weight; all staff used total mechanical lift (Hoyer lift) to transfer them from bed to wheelchair. When the resident was alert, strong enough and able to bear weight, they sometimes transferred the resident during the personal care alone, without assistance of another staff, using the pivot techniques.

Staff #146 acknowledged that they had transferred the resident alone using pivot technique on an identified date. Staff #111, #116, and #145 denied transferring the resident without lift and assistance of another person, which contradicted their documentation on the flow sheets.

Interview with staff #102 acknowledged that staff had not used safe transferring techniques when assisting resident #008. (502)

4. Based on the finding of non-compliance for resident #013, two other residents' transfers were observed.

On an identified date and time on an identified spa room the inspector observed staff #144 and #145 transferred resident #020 from wheelchair to shower chair using a sit to stand lift, with the sit to stand sling. The staff placed the sit to stand belt around the resident, secured the resident's legs on the lift foot rest, placed the resident's hands on the handle, and then they pulled the resident up with the lift to a standing position. At approximately 60 degree angle, both staff moved the resident from the wheelchair to the shower chair. Staff #145 assisted resident to sit on the shower chair while staff #144 manipulated the lift.

The observation in the resident's room revealed a transfer logo that indicated Hoyer lift and full sling transfer with two person assistance.

Review of resident #020's written plan of care completed on an identified date revealed specified medical condition. The plan of care indicated resident #020 required full support of two staff to transfer safely.

Review of SALT assessment completed on an identified date indicated that

resident #020 required total mechanical lift (Hoyer or ceiling lift) with the assistance of two staff members for all transfers.

In an interview, staff #144 confirmed that they assisted staff #145, (who was the resident's primary care giver), with the transfer of resident #020 using the sit-to-stand mechanical lift from wheelchair to shower chair, and had not realized that it was wrong. They stated that they had not checked the transfer logo before assisting staff #145 to transfer the resident from wheelchair to shower chair and that it was a mistake.

In an interview, staff #145, stated that they had been employed in the home for five months and they were aware that resident #020 required total mechanical lift (Hoyer lift). However, when a resident sits on the wheelchair the practice among staff is to use the sit to stand lift to transfer on and off the toilet or shower chair. Staff #145 indicated that they became aware of that practice during orientation and all PSWs are doing the same.

In an interview, staff #102 stated that staff cannot change the level of assistance needed for transferring a resident (especially from total lift transfer into sit-to stand lift, or without a mechanical lift) unless the resident was assessed by the SALT team. They stated that the home's expectation was for staff to follow the transfer logo posted above each resident's bed and the plan of care. The ADOC acknowledged that staff used unsafe transferring techniques when they assisted resident #020, as they put the resident at risk of injury and fall. (502)

5. During the initial tour of the home, the inspector observed staff #111 and staff #112 carried and moved resident #013 from bed to shower chair. Further observation in the resident's bedroom revealed a transfer logo above the resident bed that indicated a mechanical lift transfer with the assistance of two person.

Review of resident #013's written plan of care completed on an identified date, indicated that they had a specified medical condition and they require mechanical lift with two person total assistance.

Review of Safe Ambulation Lift and Transfer (SALT) assessment from the home electronic documentation system Point click Care (PCC) completed on an identified date indicated that resident #013 requires assistance from two staff using mechanical lift for all transfers.

In separate interviews, staff #111 and #112 stated that they were aware of resident #013 requiring mechanical lift with two person total assistance during all transfers. Staff # 111 stated that they had transferred the resident manually because the lift was hard on them, as they had a specified medical condition, and it was easy for them to transfer the resident without the mechanical lift. Staff #111 told the DOC during the home's fact findings that the resident cannot bear weight it was comfortable and safe to carry them that way.

Staff #112 stated that staff #111, who was the resident's primary care giver, had called them for assistance and told them that the resident was easy to carry, as they were not heavy. Staff #112 confirmed that they had assisted staff #111 with the transfer of resident #013 without a mechanical lift from bed to shower chair.

In an interview, staff #113 stated staff #111 indicated that it was better for the resident to be transferred manually due to their specific medical condition. Staff #113 stated that PSWs should not change the transfer method based on what they believed it is better for the resident, but should report that to registered nursing staff, who will refer the resident to the SALT team for reassessment.

In an interview, staff #102 acknowledged staff #111 and #112 had not used safe transferring techniques when assisting resident #013. Staff #102 stated that the home's expectation was for staff to follow the transfer logo that was posted in the room and updated as per each resident's plan of care.

The severity of this issue was a level 2 as there was a risk of actual harm to the residents. The scope was level 3 as it related to five of five residents reviewed that were not transferred using safe transferring techniques or device. The home had a level 2 history as the non-compliances were unrelated with this section of the LTCHA. Based on the severity, the scope, and the home's compliance history with section r.36, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2018

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 10th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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Name of Inspector / Nom de l'inspecteur : Julienne NgoNloga

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