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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2016	2016_275536_0018	030586-16	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Waterford Long Term Care Residence
2140 Baronwood Drive OAKVILLE ON L6M 4V6

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

CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)

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): October 24, 25, 26, 27, 28, November 1 and 2, 2016.

The following inspections were completed concurrently with the RQI:

Complaints

018180-15-related to: hospitalization and change in condition
021488-15-related to: shortage of supplies
006117-16-related to: elopement and personal support services

Critical Incident System Reports:

019841-15-related to: prevention of abuse and neglect
006658-16-related to: transferring and positioning
008315-16-related to: prevention of abuse and neglect
016675-16-related to: medication error
019033-16-related to: fall prevention
023302-16-related to: prevention of abuse and neglect
025362-16-related to: transferring and positioning
027250-16-related to: fall prevention
029023-16-related to: fall prevention
030402-16-related to: prevention of abuse and neglect

Follow ups:

022775-15-related to transferring and positioning

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSWs), registered staff, Environmental Services Manager, Assistant Director of Care (ADOC), Director's of Care (DOCs) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes 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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council

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

- **5 WN(s)**
- **2 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 used safe transferring and positioning devices or techniques when assisting residents.

A) According to their Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment completed on an identified date in 2016, resident #012 required extensive

assistance from two staff for transferring. The document the home referred to as resident #012's care plan, directed staff that two staff should provide total assistance for transferring the resident.

According to the home's investigative notes, on an identified date, Personal Support Worker (PSW) #116 failed to transfer resident #012 according to their plan of care. The resident sustained an injury, for which they required medical intervention.

During interview, the PSW confirmed that they did not follow the resident's plan of care and transferred the resident by themselves.The PSW and Director of Care (DOC) #104 confirmed that the staff did not use safe transferring techniques when transferring resident #012, and that this contributed to the resident being injured.

B) According to their clinical records, resident #007 required extensive assistance from two staff for transferring. The document the home referred to as resident #007's care plan, indicated that the resident had pain and directed staff to use a specified device during transfer.

The home submitted a critical incident system (CIS) regarding an unexplained injury to resident #007, that the resident stated had occurred during care. During interview PSW #108 reported that they assisted PSW #101 to transfer resident #007 and that the resident was not in distress just prior to them leaving to assist other residents. When PSW #108 returned to assist PSW #101 to transfer the resident again, the resident complained of being uncomfortable.

During interview, PSW #101 stated that after PSW #108 assisted with the transfer, PSW #108 left to assist other residents. PSW #101 then saw that the resident was not positioned correctly. According to the PSW, the resident began to complain of pain. PSW #101 stated that they did not take steps to more safely position the resident or notify registered staff, even though resident #007 continued to complain of pain. PSW #101 stated that the resident became more comfortable after they were transferred. They also stated that they saw a injury after assisting the resident but, failed to report this to registered staff.

During interview PSWs #101, #108 and #109 stated that if a resident was unsafely positioned and had pain, staff should reposition them and report the resident's pain to the registered staff.

During interview, the DOC #104 confirmed that PSW #101 did not use safe positioning techniques with resident #007 and that this resulted in the resident experiencing pain.

C) According to their health records, resident #008 required extensive assistance from two staff for bed mobility. During interview with PSW #121 they confirmed, that the resident was unable to reposition themselves independently while in bed.

According to the home's CIS submission, during care PSW #120 reportedly pushed the resident toward PSW #118, without warning. According to the home's investigative notes and interviews with PSW #118 and #120, PSW #120 did not collaborate with PSW #118 to position the resident safely. There was no apparent injury to resident #008. The DOC #104 confirmed that PSW #120 did not safely reposition resident #008, and that this placed the resident's safety at risk, given their need for extensive assistance with bed mobility. [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. 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 failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) According to their clinical record, resident #001 was totally dependent on two staff for identified areas of care, and required extensive assistance from two staff. According to the home's CIS submission, the resident complained that Personal Support Worker (PSW) #113 spoke loudly and rudely to them. During interview the resident stated, that PSW #113 treated them badly.

During interview, the Director of Care (DOC) stated that the PSW confirmed that they spoke loudly to the resident. The PSW denied the allegations during interview with the MOHLTC Inspector. The PSW was instructed to not care for resident #001 after this incident and was disciplined. The home's investigative notes confirmed that the staff yelled at the resident. During interview, DOC #104 stated that the home's investigation of this allegation confirmed verbal abuse had occurred with resident #001 by PSW #113.

B) According to the home's Critical Incident System (CIS) submission, PSW #118 and #120 were providing care to resident #008 while working on an identified home area. PSW #118 sustained an injury reportedly when PSW #120 unsafely repositioned the resident. During interview with the MOHLTC Inspector and during the home's investigation PSW #120 stated that they were angry at their co-worker and staff were talking very loudly at each other in the presence of residents. During interview, PSWs #118 and #120 stated that a high volume of voice when a staff person was angry could be viewed as intimidating to the residents living in the home.

During interview, the DOC confirmed that PSWs' high tone of voice toward co-workers in the presence of cognitively impaired residents constituted emotional abuse. [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 and ensuring that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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.

A) The home's "Transfer to Hospital" policy number: LTC-CA-WQ-100-02-05, last revised: November 2014, included directions to staff to follow when a resident was to be transferred to hospital:
a) "Notify reception that an ambulance is on its way, for whom and the room number. If the call is after hours and there is no reception, assign a staff member to the front door to await the ambulance and escort the ambulance staff to the resident's location";
b) "Complete/obtain the following and send with the resident: transfer record from Point Click Care; ensure the reason for the transfer is clearly documented on the Transfer Form"; and
c) "Provide a history and any needed information to the ambulance staff and provide copies of all forms necessary."

According to clinical records, resident #003's health deteriorated and they required transfer to hospital. During interview, the resident's family member complained that the paramedic service arrived and there were no staff available to provide them with information about the resident who required transfer to hospital. A progress note by the home's chaplain, confirmed that a staff member had not been assigned to the front door to await the ambulance and escort the ambulance staff to the resident's location. The chaplain in turn accompanied them to the resident's room.

The family member complained that the paramedic service received no information and were provided no transfer papers when the resident was sent to hospital. They stated that hospital staff told them that they had very little history about the resident's care needs. A review of records obtained from the hospital indicated that the paramedic service waited five minutes in the home before being given direction by a registered staff that resident #003 was to be sent to hospital. The note further indicated that the registered staff #122 who provided information to paramedic staff did not know the resident, and did not know the health history regarding need for the hospitalization.

During interview, staff #105 stated that they had prepared the papers and notes according to the home's policy and left them for staff #122 to give to paramedics. During interview, staff #122 stated that they provided the papers to the paramedic staff according to the home's policy and included the resident's electronic medication administration record (eMAR) , the Transfer/discharge record, and the resident's resuscitation status. Review of hospital notes indicated that these papers were received by paramedics and given to hospital staff. However, review of the Transfer/Discharge Report by the Ministry of Health and Long Term Care(MOHLTC) Inspector indicated that the following fields were empty: 'Chief Complaint (reason for transfer)', 'Relevant information', and 'Miscellaneous information'.

During interview, the home's Administrator confirmed that the home's "Transfer to Hospital" policy was not complied with when paramedic staff had to wait for registered staff to provide information about the resident for transfer to hospital, and when the reason for transfer was not clearly documented on the transfer form that was sent to hospital.

B) During the course of this inspection, the MOHLTC Inspector reviewed the home's policies and procedures in relation to Personal Support Workers (PSWs) reporting alterations in skin integrity and pain concerns to registered staff:

1) "PSW Job Description" dated October 2014, indicated that PSW 'Key Activities' included "Responds to resident or family member concerns and ensures appropriate action is taken within decision-making authority and/or brings to the attention of immediate supervisor"; and "Assists in the monitoring of care given to residents ensuring it is in accordance with the established plan of care by observing residents and reporting findings to immediate supervisor".

2) The home's "Long Term Care (LTC) Care Staff Guide Book" version September 2012

directed PSW staff as follows: Shift reporting: "Significant resident observations should not be left to the end of shift to be reported, rather significant observations should be reported as close to the time of observation as possible"; and as per DOC #104, all forms of altered skin integrity including bruising, PSW staff were directed: "Should a resident develop or sustain a skin tear [or any other area of altered skin integrity according to the home's expectations]: notify registered staff immediately".

3) The home's "Wound Care Treatment" policy number: LTC-CA-WQ-200-08-03, last revised: November 2015, directed staff: "Upon causing or the discovery of a skin tear, care staff is to report this to the registered staff".

4) The home's "Pain" policy number LTC-CA-WQ-200-05-04, last revised July 2016, directed staff as follows: "Ongoing Registered Staff and all other members of the interdisciplinary care team are to be alert to signs that a resident may be experiencing pain. Team members observing any of these signs are to report these to Registered Staff immediately".

According to their health record, resident #007 required extensive assistance from two staff for transferring using a mechanical lift. The document the home identified as resident #007's care plan indicated that the resident had pain and also had fragile skin.

According to the home's Critical Incident System (CIS) submission, resident #007 reported to registered staff #107 that they had sustained an injury while receiving assistance from PSW #101. When asked, the resident could not recall how the injury had occurred.

During the home's investigation of the incident, PSW #101 reported that they saw the injury, but did not report it to their direct supervisor or registered staff according to the home's policies. They stated that they were not aware of the source of the injury.

During interview, PSW #101 stated that when resident #007 was transferred, they were poorly positioned. The resident began to complain of pain due to their poor positioning. PSW #101 stated that they did not take steps to more safely position the resident, even though resident #007 continued to complain of pain. The PSW also confirmed that they did not follow the home's policy when they did not notify the registered staff of the resident's pain or take steps to address it.

During interviews, PSWs #108 and #109 confirmed that PSWs in the home were

required to inform the registered staff when a resident was experiencing pain, or when they saw any areas of altered skin integrity including bruising on the resident. The Director of Care (DOC) confirmed that PSW #101 did not follow the home's policies when they failed to report resident #007's area of altered skin integrity as well as their pain on October 17, 2016. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the complaint and transfer to hospital policies are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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 plan of care set out clear directions to staff

who provided direct care to resident #009.

A review was completed of resident #009's clinical record. The resident had an identified number of falls between 2015 and 2016. The Post Fall Analysis dated on an identified date, specified that the resident had a high/low bed at the time of the resident's fall. The plans of care for resident #010 which the home refers to as the care plan did not indicate that the resident had a high/low bed in place. The Director of Care(DOC) #104 confirmed that the resident did have a high/low bed and it was not in the resident's care plan. [s. 6. (1) (c)]

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

A) According to the document the home refers to as resident #001's care plan last updated on an identified date in 2016, staff were directed to do the following: "Adapt care routine according to [resident's] preference" and "staff to ensure that they follow [resident's] direction to decrease [their] frustration and to prevent them from getting upset and verbally responsive to staff".

During interview with Ministry of Health and Long Term Care (MOHLTC) Inspector, resident #001 reported that Personal Support Worker (PSW) #113 had refused to give them supplies during the evening shift for care that would normally be provided by the night shift, and that this had caused them great anxiety. The resident reported that they complained about this to registered staff #106 during the previous year. During interview PSW #113 confirmed that resident #001 would ask for supplies, but not usually from them. During interview, registered staff #106 confirmed that resident #001 had complained to them about PSW #113 not giving them supplies, and stated that it was not the evening shift PSWs' responsibility to provide supplies that were needed on night shift. The registered staff stated that they would provide the supplies if they were working. The registered staff and Director of Care (DOC) #104 confirmed that the plan of care was not updated to accommodate this specific request, and that staff had not followed the plan of care by not adapting their care routine according to resident #001's preferences, as directed in the care plan. 526

B) According to their clinical record, resident #011 required extensive assistance from two staff, and the use of a mechanical lift for transferring. A review of the home's investigative notes indicated that PSW #113 transferred the resident without the use of a mechanical lift or another staff.

During the home's investigation and interview with the MOHLTC Inspector, PSW #113 confirmed that they had transferred resident #011 by themselves and without the use of a mechanical lift according to their plan of care. The PSW stated that they thought that they could carry the resident themselves because the resident seemed able. The PSW confirmed that they knew that they were not following the plan of care, did not ask for assistance from other staff, and that they placed the resident's safety at risk. The DOC #104 confirmed, that PSW #113 had not provided the care as specified in the plan of care for resident #011. [s. 6. (7)] 526

3. The licensee has failed to ensure that resident #002's plan of care was reviewed and revised at least every six months and at any other time that the resident's care needs changed.

Resident #002 health status began to decline. At that time it was decided by the physician and the substitute decision maker (SDM) that the resident would receive comfort measures only. On an identified date, the resident was deemed palliative care. A review of resident #002's clinical record identified that the plan of care which the home refers to as the care plan, was not updated to reflect that the resident had become palliative care. Resident #002's care plan also identified that pain management had not been updated to reflect the changes made by the physician when the resident was deemed palliative care. The Director of Care (DOC) #104, identified that resident #002's care plan was not updated to reflect that they were palliative care, or any changes to the resident's pain management. [s. 6. (10) (b)] 536

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. (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 was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

During interview, resident #001 reported to the Ministry of Health and Long Term Care (MOHLTC) Inspector that Personal Support Worker (PSW) #113 had refused to provide them with supplies. The resident stated that they had complained to registered staff #106 at least three times, but that the issue had not been resolved and they continued to feel upset. During interview registered staff #106 confirmed that resident #001 had complained that PSW #113 would not give them supplies at least three times in the past several months. The registered staff specified that they had addressed the issue with PSW #113 but had not addressed the issue again even though the resident continued to complain about it. The registered staff stated that they would personally provide supplies to the resident or ask another staff to do it, but had not taken steps to investigate or fully resolve the issue. The registered staff also stated that even though the resident asked for them, the PSW did not have to provide supplies to the resident as the supplies weren't needed until the next shift.

The home's Risk Management Policy "Complaints" number LTC-CA-WQ-100-05-08 last revised January 2016, directed staff as follows: "The individual receiving a verbal complaint will deal with the concern if it is within their abilities. If the verbal complaint received is not within their abilities to respond, the person receiving the complaint will contact the department manager who can address the issue". Registered staff #106 confirmed that they should have contacted the Director of Care (DOC) with resident #001's complaint, but that they had failed to do this. They stated that they thought that the resident had already spoken with the DOC.

DOC #104 and registered staff #106 confirmed that the home's Complaints policy had not been followed since they had not communicated the complaint to their direct supervisor. DOC #104 confirmed that the issue was not investigated or resolved where possible, according to legislative requirements. [s. 101. (1) 1.]

Issued on this 1st 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2016_275536_0018
Log No. / Registre no:	030586-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 18, 2016
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Waterford Long Term Care Residence 2140 Baronwood Drive, OAKVILLE, ON, L6M-4V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Widdicombe

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_301561_0008, CO #001;

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 ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The licensee shall do the following:

Transfers:

1) Safely transfer residents #007 and #012 according to the resident's plans of care and the home's policies;
2) Audit transfers of residents #011 and #012 to ensure that they are conducted safely, according to the resident's plan of care and the home's policies;
3) Retrain PSW's #113 and #116 in safe transfers according to resident's plan of care and the home's policies; and
4) Audit transfers completed by PSW's#113 and #116 and document these audits.

Positioning:

1) Safely re-position residents #007 and #008 according to the resident's plans of care and the home's policies;
2) Audit positioning of residents #007 and #008 to ensure that they are conducted safely, according to the resident's plan of care and the home's policies;
3) Retrain PSW's #101 and #120 in safe positioning according to resident's plan of care and the home's policies; and
4) Audit positioning completed by PSW's #007 and #008 of resident, and document these audits.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (3), scope (3), and compliance history (4), in keeping with r. 36 of the Regulation. This is in respect to the severity of potential or actual harm that the identified resident's experienced, the scope of this being widespread incidents, and the licensee history of non-compliance with a (CO) in June 2015, during the Resident Quality Inspection for r. 36.

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

A) According to their Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment completed on an identified date in 2016, resident #012 required extensive assistance from two staff for transferring. The document the home referred to as resident #012's care plan, directed staff that two staff should provide total assistance for transferring the resident.

According to the home's investigative notes, on an identified date, Personal Support Worker (PSW) #116 failed to transfer resident #012 according to their plan of care. The resident sustained an injury, for which they required medical intervention.

During interview, the PSW confirmed that they did not follow the resident's plan of care and transferred the resident by themselves.The PSW and Director of Care (DOC) #104 confirmed that the staff did not use safe transferring techniques when transferring resident #012, and that this contributed to the resident being injured.

B) According to their clinical records, resident #007 required extensive assistance from two staff for transferring. The document the home referred to as resident #007's care plan, indicated that the resident had pain and directed staff to use a specified device during transfer.

The home submitted a critical incident system (CIS) regarding an unexplained injury to resident #007, that the resident stated had occurred during care. During interview PSW #108 reported that they assisted PSW #101 to transfer resident #007 and that the resident was not in distress just prior to them leaving to assist other residents. When PSW #108 returned to assist PSW #101 to

transfer the resident again, the resident complained of being uncomfortable.

During interview, PSW #101 stated that after PSW #108 assisted with the transfer, PSW #108 left to assist other residents. PSW #101 then saw that the resident was not positioned correctly. According to the PSW, the resident began to complain of pain. PSW #101 stated that they did not take steps to more safely position the resident or notify registered staff, even though resident #007 continued to complain of pain. PSW #101 stated that the resident became more comfortable after they were transferred. They also stated that they saw a injury after assisting the resident but, failed to report this to registered staff.

During interview PSWs #101, #108 and #109 stated that if a resident was unsafely positioned and had pain, staff should reposition them and report the resident's pain to the registered staff.

During interview, the DOC #104 confirmed that PSW #101 did not use safe positioning techniques with resident #007 and that this resulted in the resident experiencing pain.

C) According to their health records, resident #008 required extensive assistance from two staff for bed mobility. During interview with PSW #121 they confirmed, that the resident was unable to reposition themselves independently while in bed.

According to the home's CIS submission, during care PSW #120 reportedly pushed the resident toward PSW #118, without warning. According to the home's investigative notes and interviews with PSW #118 and #120, PSW #120 did not collaborate with PSW #118 to position the resident safely. There was no apparent injury to resident #008. The DOC #104 confirmed that PSW #120 did not safely reposition resident #008, and that this placed the resident's safety at risk, given their need for extensive assistance with bed mobility. [s. 36.] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 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
TORONTO, 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
TORONTO, 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 18th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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