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
Jul 27, 2017	2017_561583_0012	002543-17, 010604-17	Complaint

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

KELLY HAYES (583), BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 8, 9, 12, 20, and 21, 2017.

The following complaint inspections were conducted concurrently with this RQI: Complaint Log #010604-17, 002543-17, safe transfers, equipment and personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director's of Care (DOCs); Assistant Director of Care (ADOC); Social Worker; Environmental Service Manager; Staffing Unit Clerks; Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); residents and families.

During the course of the inspection, Inspectors interviewed staff, reviewed clinical records, observed care provided, reviewed relevant polices and procedures, reviewed maintenance records observed equipment and spoke to service contractors.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Hospitalization and Change in Condition
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented to ensure that electrical equipment, including medical devices were kept in good repair and maintained at a level that met manufacturer specifications.

The licensee had developed a number of written procedures to ensure that medical devices were inspected at specified intervals by designated individuals.

Maintenance staff were required to inspect all of the equipment monthly, to ensure "controls were working properly". This would have included but not be limited to the limit switch, battery and charger output and emergency release mechanisms. However no monthly maintenance records were completed in 2017. As per the licensee's policy and the manufacturer of the various devices in the home, an annual inspection and load test was also required. During an identified period in December 2016, an external contractor who specialized in lift equipment, tested and inspected the various devices. However, five devices motors were observed in use in the home that were not documented as inspected (PS06624, PS6017, PS06598, PS05342 and PS05036). An inventory of the motors used in the home completed by the DOC #101 February 14, 2017, did not include motors PS05342 and PS05036, which were observed in use in identified home areas during the inspection. No formal record could be provided to determine if the technician completed a full inspection of the five device's listed above.

Personal Support Worker (PSW) staff were required to check and document the condition of the various devices prior to each use and to ensure that faulty equipment was tagged out. The check list with a specified title used by the PSWs did not include the need to check the device to ensure a specific part was attached for resident safety. During the inspection, two units were found to be faulty (PS6596 & PS06623) and six units were missing one or more of the required parts for the device. The completed checklists for an identified two and a half month period in 2017, motors PS06596, PS06417 and PS05342 were not included in the package requested for review. The majority of the medial devices checked by staff identified that the equipment was in working order, even though multiple medical devices were pulled from circulation to have equipment and batteries replaced. Records did not always reflect accurately what was occurring with the medical devices.

A complaint was received in 2017, identifying that medical devices in the home were not in good repair, that there were no spare devices and that the chargers for the units were in short supply. The Ministry of Labour came to the home in February 2017, and reviewed the availability of chargers and specified medical devices in the home. As a

result, an inventory of available equipment was completed by management staff and five new chargers were ordered.

During the inspection, over six PSWs and several registered staff were interviewed who reported being involved in or knew about four separate incidents where a medical device malfunctioned during use The PSWs reported that they did not feel confident in using the devices because they did not know when it would fail. Upon further investigation, it was determined that there were multiple identified contributing factors as to why the medical devices did not function properly, these details were shared with the licensee.

Maintenance work requests completed by staff between January and June, 2017, included 12 records, which identified various failures with the use of the medical devices. None of the 12 records had a unique number to verify which medical device's motor was being referenced. According to service reports completed by an external contractor, each of the 8 motors (identified with a serial number) were serviced between February and June 19, 2017. Motor PS06017 had the belt replaced in March and June 2017, motor PS06036 had the battery replaced in February and March and motor PS06417 had the battery replaced in February and June 19, 2017. Other motors had either specified equipment, batteries or the hand control replaced. According to the manufacturer, the battery life expectancy is more than one year when used properly. Despite the frequency with which the device's motors were being repaired or had components replaced, the condition of the ceiling motors could not be relied upon.

The service contractor reported that the number of service repairs to the motors was above average and that they would become increasingly difficult to service if older than 10 years. The service contractor reported that when he arrived to the home to repair a motor, typically, no information was included with the motor to inform him of what transpired before it was tagged out. The motors were confirmed to have been in use since May 2005, well beyond the manufacturer’s suggested guideline of a 10 -year life expectancy. The manufacturer's specifications for care and maintenance included that the emergency release mechanisms and the limit switch was to be inspected annually, which was completed in December 2016. However, with the high use of the motors and their age, the service contractor recommended that these functions be checked more frequently by a maintenance person in the home.

The procedures were therefore not implemented to ensure that electrical equipment, specifically the specified medical devices, were kept in good repair. [s. 90. (2) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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. Where this Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the licensee failed to ensure that the policy and procedures were complied with.

As part of the continuous quality improvement and utilization review system required under section 84 of the Act, Ontario Regulation 79/10, s.228 (1) and (2) requires that there are policies and procedures to identify initiatives for review and to ensure the system must be ongoing and interdisciplinary.

The "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy, last revised May 2017, was reviewed. It provided the homes staff with concrete steps and directions on how to conduct investigations and document findings. Including but not limited to the following:

- Interviewing those involved in the event directly and all witnesses of the event
- Obtaining written statements
- Include equipment logs if equipment was involved and failed
- Come to a conclusion
- Develop a plan to prevent a recurrence

- Write a report

A) On an identified date in 2016, a medical device malfunctioned during use for resident #101. Progress notes related to the incident identified staff were unable to release the device and staff proceeded to contact maintenance. In June 2017, staff #116 and #118, direct care staff, present at the time of the incident, were interviewed. They shared the resident was upset and agitated during the incident. The resident was not injured during the incident.

Staff #118 shared the equipment was tagged and taken out of service and that DOC #101 was notified of the incident. On June 20, 2017, Inspector #583 asked staff #116 (who was present when the incident occurred), if they were interviewed by anyone during the homes investigation about the incident. They shared no one spoke to them after the incident occurred and they were not aware why the device failed.

At the time of the inspection no investigation notes were available and it was confirmed by DOC #101 and #102 on June 21, 2017, that an investigation was not completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy.

B) i) On an identified date in 2017, a medical device malfunctioned during use for resident #102. It was later identified by Inspector #120 after completing interviews with the service contractor what occurred with the equipment.

A review of resident #102's clinical records and interviews with the DOC's confirmed that there was no documentation in the resident's plan of care related to this incident. At the time of the inspection a brief note completed on a "Complaint Communication Log" was provided. It was confirmed by DOC #102 that the documentation was completed on an identified date in 2017, approximately one week later. Information was not gathered in the detail directed in the homes policy. It was confirmed by DOC #101 and #102 in June 2017, that the home proceeded with an investigation during our inspection and that an investigation was not completed at the time of the incident.

ii) On another identified date in 2017, a second incident occurred with a medical device malfunctioning during use for resident #102. A progress note documented on an identified date in 2017, noted the resident sustained a minor injury during the incident and that the documentation noted the DOC was informed.

On and identified date in June 2017, Inspector #583 asked staff #114 (who was present at the time of the incident), if they were interviewed by anyone during the homes investigation about the incident. They shared no one spoke to them after the incident occurred and they were not aware why the lift failed.

At the time of the inspection no investigation notes were available and it was confirmed by DOC #101 and #102 in June 2017, that an investigation was not completed. It was confirmed that an investigation was not completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy.

C) On an identified date in 2017, a medical device malfunctioned during use for resident #100. During the incident the resident sustained a minor injury and per the Nurse Practitioner assessment the resident had pain in identified areas.

A "Compliant Investigation Form", "Complaint Communication Log" and one additional page of hand written notes were provided to inspector #583 by DOC #001. In an interview with DOC #001 and #002 it was shared that documentation was not competed at the time of the incident. It was later confirmed with DOC #002 that the information provided referencing resident #100 was a combination of an incident with resident #102 on an identified date in 2017 and resident #100 on an identified date in 2017. It was confirmed that detailed fact finding interviews were conducted at the time of this inspection not at the time of the incident.

It was confirmed that an investigation was not completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy. In an interview with the Administrator on June 20, 2017, it was confirmed that an investigation for the four unsafe transfer incidents should have been completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy, last revised May 2017. It was shared that information gathered through the homes risk management investigations were used to monitor, analyzes and improve the quality of the accommodation and care services. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee failed to ensure that all staff, who were required to use as part of their responsibilities received training on how to use therapeutic equipment, mechanical lifts, assitive aids and positioning aids in accordance with the manufacturers' instructions.

For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following additional areas were to be provided with respect to training: Safe and correct use of equipment, that is relevant to the staff member's responsibilities. Section 76(2), paragraph 11 of the Act, refers to all staff receiving training before beginning their responsibilities in any area provided for in the regulations. Section 23 of the regulation requires the licensee to ensure that all staff, who are required to use therapeutic equipment, mechanical lifts, assitive aids and positioning aids as part of their responsibilities, use the equipment in accordance with manufacturers' instructions.

According to staff observations, staff interviews, maintenance documentation and discussions with lift specialists and lift trainers, the licensee did not provide staff with training that included all of the necessary manufacturers' instructions to use the equipment safely.

Five similar incidents involving residents occurred related to the specified equipment on an identified date in 2016, and four on identified dates in 2017.

Two units were found in two separate home areas, with equipment in poor repair

(PS06596 & PS06623), a sign that a specified part on the equipment may not have been used correctly. More than two other motors had the part replaced in 2017 due to the same reason. Dead batteries were commonly replaced, motor PS06036 had the battery replaced in February and March, motor PS06417 had the battery replaced in February and June 2017. Each of these batteries did not last more than several months, even though according to the manufacturer, it would be expected that they would last over a year.

None of the PSWs interviewed knew that operating the equipment in a specified way could cause a malfunction.

Two out of the three PSWs were observed to operate the equipment incorrectly.

Six specified pieces of eqipment were observed to be missing parts needed for resident safety. Only one PSW in one home area identified the issue and requested that more of the specified parts be ordered in February 2017.

DOC #103, reported that it was her role to ensure that education and training was provided to all staff who used the specified equipment in the home. She also stated that she and five PSWs received more extensive training by a representative of the manufacturer to become certified trainers.

According to records, they received training in September 2016, so that they could train the remaining staff on the safe and proper use of the specified equipment. The remaining staff all received training by either the DOC or one of the PSWs between November 2016 and January 2017. Approximately 38% the staff received training by a certified PSW. PSW#121, a certified trainer and the DOC reported that each staff member received a 20 minute demonstration (hands on) review of how 3 different types of equipment were intended to be used. It included a verbal review of how the emergency mechanism was supposed to work, but the PSWs did not get to test it out. The trainers, when trained by the manufacturer's representative, were shown how the two emergency mechanisms worked. The trainer confirmed that they did not show the certified PSW trainers how the motors would react in a specified circumstance. It is not known what the other trainers taught other PSWs and whether the information was conveyed consistently.

The DOC acknowledged that staff were not re-assessed after receiving the training to determine if they used the specified equipment correctly, but confirmed that staff

demonstrated what they learned only during training. The training did not consist of any video material, a review of the manufacturers' written guidelines or a test of each trainee's understanding of the specified equipment. Specifically, the training did not include the emergency release functions as a necessary part of safe and correct use of equipment, an understanding of the limitations of the equipment when residents in specified situtations, properly identifying lift equipment not in good condition and proper documentation and tag out procedures for all equipment. [s. 218.]

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 all staff, receive required training for the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for the resident set out the planned care for the resident.

Documentation completed in resident #101's clinical record identified that on an identified date in 2016, a medical device malfunctioned.

The care plan identified the resident was to receive an identified intervention from two staff using a device, but did not identify the specific individualized device to be used with the medical device. During an interview with the ADOC in July 2017, it was confirmed that at the time of the incident the plan of care did not set out the type of device staff were to use when care was provided. It was confirmed the written plan of care for resident #101 did not set out the planned care for the identified intervention. [s. 6. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments , interventions and the residents responses to interventions were documented.

Multiple interviews with PSW's, registered nursing staff, Environmental Service Managers, DOCs and the ADOC were completed during the course of the inspection. During these interviews it was confirmed that on and identified date in 2017, a medical device malfunctioned for resident #102 and the resident had to be manually removed from the device by staff.

In an interview with DOC #101 and #102 on June 21, 2017, it was shared that resident #101 was assessed after the incident by the RN #117 and the resident had no injuries. After a review of resident #101's clinical records and interviews with the DOC's it was confirmed that there was no documentation in the resident's plan of care related to this incident. It was confirmed that actions taken with respect to resident #102 on an identified date in 2017, including assessments, interventions and the resident's responses to interventions were not documented. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the designated lead for housekeeping, laundry and maintenance had a post-secondary degree or diploma or knowledge of evidence-based practices and, if there were none, prevailing practices related to housekeeping, laundry and maintenance.

The Environmental Services Manager was hired in January 2017, by the administrator of the home. The administrator was aware that the manager did not have a post-secondary degree or diploma. As the Environmental Services Manger they were required to have knowledge of prevailing practices relating to housekeeping, laundry and maintenance and to hold a post-secondary degree or diploma.

The manager confirmed that he did not have a degree or diploma, but certificates from a post- secondary institution. The manager also confirmed that he was not aware of the prevailing practices in laundry or housekeeping and had some knowledge of maintenance related prevailing practices. [s. 92. (2)]

Issued on this 29th day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_561583_0012
Log No. / No de registre :	002543-17, 010604-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 27, 2017
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:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall complete the following:

1. Inventory all specified equipment in the home and have the contracted technician inspect those that were not part of the annual load test completed in December 2016.

2. Maintain accurate records of all specified equipment in the home, including the date of installation, serial number, type and model and a repair history of each unit.

3. As per the home's policies regarding the specified equipment, a maintenance person with training and skills to inspect lift equipment shall inspect each medical device monthly for functionality.

5. Develop and implement an equipment replacement program for lifts that have been identified by a technician or the manufacturer as beyond the suggested life expectancy.

6. Train all staff who use the specified equipment with the following:
i) what to document when the equipment is not functioning (serial number or unique equipment identifier, date of malfunction, who was using it when it malfunctioned, what room the lift was used in and what occurred just before it malfunctioned)
ii) where to document the information identified above (lock out tag and environmental services work request form)
iii) where the equipment must be stored when it is tagged out

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is a pattern (2), the severity of the non-compliance has actual harm or risk (3) and the history of one or more related non-compliance in the past three years, under Ontario Regulation 79/10, r. 110. (1) 1 is ongoing (4) with a CO issued on July 27, 2015.

1. The licensee did not ensure that procedures were implemented to ensure that electrical equipment, including medical devices were kept in good repair and maintained at a level that met manufacturer specifications.

The licensee had developed a number of written procedures to ensure that medical devices were inspected at specified intervals by designated individuals.

Maintenance staff were required to inspect all of the equipment monthly, to ensure "controls were working properly". This would have included but not be limited to the limit switch, battery and charger output and emergency release mechanisms. However no monthly maintenance records were completed in 2017. As per the licensee's policy and the manufacturer of the various devices in the home, an annual inspection and load test was also required. During an identified period in December 2016, an external contractor who specialized in lift equipment, tested and inspected the various devices. However, five devices motors were observed in use in the home that were not documented as inspected (PS06624, PS6017, PS06598, PS05342 and PS05036). An inventory of the motors used in the home completed by the DOC #101 February 14, 2017, did not include motors PS05342 and PS05036, which were observed in use in identified home areas during the inspection. No formal record could be provided to determine if the technician completed a full inspection of the five device's listed above.

Personal Support Worker (PSW) staff were required to check and document the condition of the various devices prior to each use and to ensure that faulty equipment was tagged out. The check list with a specified title used by the PSWs did not include the need to check the device to ensure a specific part was attached for resident safety. During the inspection, two units were found to be faulty (PS6596 & PS06623) and six units were missing one or more of the required parts for the device. The completed checklists for an identified two and a half month period in 2017, motors PS06596, PS06417 and PS05342 were not included in the package requested for review. The majority of the medial devices checked by staff identified that the equipment was in working order, even though multiple medical devices were pulled from circulation to have equipment and batteries replaced. Records did not always reflect accurately what was occurring with the medical devices.

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completed by management staff and five new chargers were ordered.

During the inspection, over six PSWs and several registered staff were interviewed who reported being involved in or knew about four separate incidents where a medical device malfunctioned during use The PSWs reported that they did not feel confident in using the devices because they did not know when it would fail. Upon further investigation, it was determined that there were multiple identified contributing factors as to why the medical devices did not function properly, these details were shared with the licensee.

Maintenance work requests completed by staff between January and June, 2017, included 12 records, which identified various failures with the use of the medical devices. None of the 12 records had a unique number to verify which medical device's motor was being referenced. According to service reports completed by an external contractor, each of the 8 motors (identified with a serial number) were serviced between February and June 19, 2017. Motor PS06017 had the belt replaced in March and June 2017, motor PS06036 had the battery replaced in February and March and motor PS06417 had the battery replaced in February and June 19, 2017. Other motors had either specified equipment, batteries or the hand control replaced. According to the manufacturer, the battery life expectancy is more than one year when used properly. Despite the frequency with which the device's motors were being repaired or had components replaced, the condition of the ceiling motors could not be relied upon.

The service contractor reported that the number of service repairs to the motors was above average and that they would become increasingly difficult to service if older than 10 years. The service contractor reported that when he arrived to the home to repair a motor, typically, no information was included with the motor to inform him of what transpired before it was tagged out. The motors were confirmed to have been in use since May 2005, well beyond the manufacturer's suggested guideline of a 10 -year life expectancy. The manufacturer's specifications for care and maintenance included that the emergency release mechanisms and the limit switch was to be inspected annually, which was completed in December 2016. However, with the high use of the motors and their age, the service contractor recommended that these functions be checked more frequently by a maintenance person in the home.

The procedures were therefore not implemented to ensure that electrical

equipment, specifically the specified medical devices, were kept in good repair. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall complete the following:

1. Investigate all incidents of equipment failure that put residents at potential risk for actual harm and all incidents where residents have been harmed.

2. Follow the home's current policies and procedures when completing investigations.

3. Implement an auditing process to ensure staff follow the concrete steps and directions on how to conduct investigations and document findings per the home's current policies and procedures.

Grounds / Motifs :

1. 1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is a pattern (2), the severity of the non-compliance has actual harm or risk (3) and the history of one or more related non-compliance in the past three years, under Ontario Regulation 79/10, r. 110. (1) 1 is ongoing (4) with a CO issued on July 27, 2015.

1. Where this Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the

licensee failed to ensure that the policy and procedures were complied with.

As part of the continuous quality improvement and utilization review system required under section 84 of the Act, Ontario Regulation 79/10, s.228 (1) and (2) requires that there are policies and procedures to identify initiatives for review and to ensure the system must be ongoing and interdisciplinary.

The "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy, last revised May 2017, was reviewed. It provided the homes staff with concrete steps and directions on how to conduct investigations and document findings. Including but not limited to the following:

- Interviewing those involved in the event directly and all witnesses of the event
- Obtaining written statements
- Include equipment logs if equipment was involved and failed
- Come to a conclusion
- Develop a plan to prevent a recurrence
- Write a report

A) On an identified date in 2016, a medical device malfunctioned during use for resident #101. Progress notes related to the incident identified staff were unable to release the device and staff proceeded to contact maintenance. In June 2017, staff #116 and #118, direct care staff, present at the time of the incident, were interviewed. They shared the resident was upset and agitated during the incident. The resident was not injured during the incident.

Staff #118 shared the equipment was tagged and taken out of service and that DOC #101 was notified of the incident. On June 20, 2017, Inspector #583 asked staff #116 (who was present when the incident occurred), if they were interviewed by anyone during the homes investigation about the incident. They shared no one spoke to them after the incident occurred and they were not aware why the device failed.

At the time of the inspection no investigation notes were available and it was confirmed by DOC #101 and #102 on June 21, 2017, that an investigation was not completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy.

B) i) On an identified date in 2017, a medical device malfunctioned during use

for resident #102. It was later identified by Inspector #120 after completing interviews with the service contractor what occurred with the equipment.

A review of resident #102's clinical records and interviews with the DOC's confirmed that there was no documentation in the resident's plan of care related to this incident. At the time of the inspection a brief note completed on a "Complaint Communication Log" was provided. It was confirmed by DOC #102 that the documentation was completed on an identified date in 2017, approximately one week later. Information was not gathered in the detail directed in the homes policy. It was confirmed by DOC #101 and #102 in June 2017, that the home proceeded with an investigation during our inspection and that an investigation was not completed at the time of the incident.

ii) On another identified date in 2017, a second incident occurred with a medical device malfunctioning during use for resident #102. A progress note documented on an identified date in 2017, noted the resident sustained a minor injury during the incident and that the documentation noted the DOC was informed.

On and identified date in June 2017, Inspector #583 asked staff #114 (who was present at the time of the incident), if they were interviewed by anyone during the homes investigation about the incident. They shared no one spoke to them after the incident occurred and they were not aware why the lift failed.

At the time of the inspection no investigation notes were available and it was confirmed by DOC #101 and #102 in June 2017, that an investigation was not completed. It was confirmed that an investigation was not completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy.

C) On an identified date in 2017, a medical device malfunctioned during use for resident #100. During the incident the resident sustained a minor injury and per the Nurse Practitioner assessment the resident had pain in identified areas.

A "Compliant Investigation Form", "Complaint Communication Log" and one additional page of hand written notes were provided to inspector #583 by DOC #001. In an interview with DOC #001 and #002 it was shared that documentation was not competed at the time of the incident. It was later confirmed with DOC #002 that the information provided referencing resident

#100 was a combination of an incident with resident #102 on an identified date in 2017 and resident #100 on an identified date in 2017. It was confirmed that detailed fact finding interviews were conducted at the time of this inspection not at the time of the incident.

It was confirmed that an investigation was not completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy. In an interview with the Administrator on June 20, 2017, it was confirmed that an investigation for the four unsafe transfer incidents should have been completed and documented according to the "05-Risk Management, (LTC-CA-WQ-100-05-01) Investigations" policy, last revised May 2017. It was shared that information gathered through the homes risk management investigations were used to monitor, analyzes and improve the quality of the accommodation and care services. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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