Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2019	2019_808535_0013	030488-18, 006520-19, 011498-19, 011579-19, 014479-19, 017828-19	Critical Incident System

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

Westside
1145 Albion Road ETOBICOKE ON M9V 4J7

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

VERON ASH (535), ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 28, 29, 30, September 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 2019.

The following intakes were completed during this inspection: Log/CIS #s: 006520-19/2663-000016-19 (related to fracture of unknown cause), 011498-19/2663-000024-19 (related to dining), 014479-19/2663-000030-19 (related to improper transfer), 011579-19/2663-000023-19 (related to fall with injury), 030488-18/2663-000034-18 (related to abuse) and 017828-19/2663-000034-19 (related to falls with injury).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant DOC (ADOC), Physiotherapist (PT), Skin and Wound Care Lead, registered staff RN/RPN, personal support workers (PSWs), substitute decision-maker (SDM) and resident.

During the course of the inspection, the inspectors made observations such as dining, staff to resident and resident to resident interactions; conducted record reviews of residents' health and staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 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	Légende 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 PSWs #131 and #117 used safe transfer and positioning devices and techniques while assisting residents #005 and #008.

An identified Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) related to improper transfer of a resident.

A review of the CIS report and the home's investigation notes indicated that on an identified date, resident #005 was found to have an injury requiring transfer to hospital for further assessment.

During the home's investigation interview, PSW #131 admitted to transferring the resident independently without a transfer device twice during their shift. The PSW verified that they were aware that the resident was assessed by the home's physiotherapist to require the use of a transfer device.

During an interview, Director of Care (DOC) #109 verified the above information and added that the PSW was disciplined as a result of the incident. Therefore, the home failed to ensure resident #005 was transferred safely to prevent an injury. [s. 36.]

2. During the onsite inspection, the inspector expanded the sample related to safe lift and transfer of residents in the home. Inspector #764 observed resident #008 being transferred by PSW #117 and PSW Student #118.

During an interview, PSW #117 verified that they were aware that the home's policy required that residents assessed for use of a transfer device be transferred with two staff; however, the PSW stated that they had been working with the student for the past week and thought it would be 'okay' to transfer the resident with the student instead of a second staff.

During an interview, DOC #109 verified that two staff were required to transfer residents using the transfer device; and that students could participate in the transfer of residents as the third person. Therefore, the home failed to ensure that staff used safe transfer and positioning devices and techniques while assisting resident #008. [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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

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

Record review of an identified CIS reported on an identified date to the MLTC indicated that there was a staff to resident altercation.

On an identified date, resident #007 complained to the Executive Director regarding an incident that occurred the previous evening. Resident #007 went on to say that on that identified date, they entered a restricted resident area when RPN #105 entered the same area and forcefully removed the resident from the area.

During observations, there were no concerns regarding staff to resident and resident to resident interactions; and resident #007 was observed using a mobility device.

Record review of resident #007’s progress notes did not reveal any injuries. Record review of the home’s investigation notes indicated that the home followed the proper procedure and notified the proper authorities in the required timeline.

During an interview, resident #007 verified that the interaction did not cause an injury.

During an interview with RPN #105, they acknowledged that they were attempting to remove the resident from the service area to protect the resident and promote safety.

During an interview, the home's DOC and ED verified that their investigation was completed; the RPN #105 was disciplined; and the home's ED agreed that the interaction between RPN #105 and the resident could have been handled more positively by the registered staff. [s. 3. (1) 1.]

Issued on this 23rd day of October, 2019

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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) :	VERON ASH (535), ORALDEEN BROWN (698)
Inspection No. / No de l’inspection :	2019_808535_0013
Log No. / No de registre :	030488-18, 006520-19, 011498-19, 011579-19, 014479-19, 017828-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 1, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Westside 1145 Albion Road, ETOBICOKE, ON, M9V-4J7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Stephanie Karapita

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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) (a)

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 of the Ontario Regulations.

Specifically, the licensee must ensure that staff use safe transferring and positioning devices or techniques when assisting residents #005 and #008 and any other resident requiring assistance by completing the following:

1. Ensure PSWs #117 and #131 have a full understanding of the home's Safe Transfer and Lift Policy and comply with that policy going forward. Please document the method of review by way of an attendance list.

2. Develop and implement a quality improvement tool to randomly audit PSWs while they are providing care to residents who require the use of safe transferring and positioning devices or techniques. Please document registered staff and management's review of the quality improvement auditing tool including an attendance list.

Grounds / Motifs :

1. The licensee has failed to ensure that PSWs #131 and #117 used safe transferring and positioning devices and techniques when assisting residents #005 and #008.

An identified Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) related to improper transfer of a resident.

A review of the CIS report and the home's investigation notes indicated that on an identified date, resident #005 was found to have an injury requiring transfer to hospital for further assessment.

During the home's investigation interview, PSW #131 admitted to transferring the resident independently without a transfer device twice during their shift. The PSW verified that they were aware that the resident was assessed by the home's physiotherapist to require the use of a transfer device.

During an interview, Director of Care (DOC) #109 verified the above information and added that the PSW was disciplined as a result of the incident. Therefore, the home failed to ensure resident #005 was transferred safely to prevent an injury. [s. 36.] (535)

2. During the onsite inspection, the inspector expanded the sample related to safe lift and transfer of residents in the home. Inspector #764 observed resident #008 being transferred by PSW #117 and PSW Student #118.

During an interview, PSW #117 verified that they were aware that the home's policy required that residents assessed for use of a transfer device be transferred with two staff; however, the PSW stated that they had been working with the student for the past week and thought it would be 'okay' to transfer the resident with the student instead of a second staff.

During an interview, DOC #109 verified that two staff were required to transfer residents using the transfer device; and that students could participate in the transfer of residents as the third person. Therefore, the home failed to ensure that staff used safe transfer and positioning devices and techniques while assisting resident #008. [s. 36.]

The severity of this issue was determined as actual risk to a resident. The scope of the issue was patterned as it relates to two out of three residents. The licensee had a previous findings of non-compliance with this section of the Ontario Regulations in September 2017, a compliance order (CO) was issued under the same section in Inspection #2017_646618_0015; and in April 2019 under the same section a voluntary plan of corrections (VPC) and a written notification (WN) were issued in Inspection #2019_650565_0005. As such, a compliance order (CO) is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2019

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

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)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 1st day of October, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Veron Ash

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