Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 26, 2020	2020_769646_0005 (A1)	020698-19, 024068-19, 024110-19, 024192-19, 001321-20, 001648-20, 002114-20	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

Amended by IVY LAM (646) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home has requested an extension to the compliance due date for order #001 due to COVID-19 outbreak. CDD is being extended to September 24, 2020. No changes made to the inspection report.

Issued on this 27th day of May, 2020 (A1)

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

Original report signed by the inspector.

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

Amended by IVY LAM (646) - (A1)

Amended 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): February 13, 14, 19, 20,

24, 25, 26, and 28, 2020. Offsite inspection activities were conducted on: February 21 and March 3, and 9, 2020.

The following intakes were inspected during this inspection:

Log #020698-19, related to a follow-up inspection on food quality,

Log #001648-20, related to neglect,

Logs #024068-19, 024110-19, and 001321-20, related to staff to resident abuse,

Log #024192-19, related to resident-to-resident abuse,

Log #002114-20, related to improper transfer.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant DOC (ADOC), Resident Services Coordinator (RSC), Recreation Coordinators, Registered Dietitian (RD), Nutrition Managers (NMs), Cook, Dietary Aides, Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Agency PSWs, Behavioural Supports Ontario (BSO) RPN, BSO PSW, and Residents.

During the course of the inspection, the inspector made observations, conducted record reviews of residents' health and staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Food Quality
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 72. (3)	CO #001	2019_808535_0014	646

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 Personal Support Workers (PSWs) #128, #130, and #131 used safe transferring and positioning techniques when assisting resident #006.

A) Critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to an incident involving resident #006. Review of the CIS report and the related incident notes indicated that on an identified date, the staff was unable to find an identified component for resident #006's wheelchair.

When resident #006 was transferred from wheelchair to bed at an identified time, the staff discovered that the resident had been sitting on the identified component, which was on the seating surface of their wheelchair. The resident had an identified altered skin integrity on an identified area of their body, which was later resolved. Skin assessment was done immediately and daily since the incident. The resident had not exhibited any pain during assessment. The affected area was cleansed and barrier cream applied. PSWs were educated to change resident’s position at identified time intervals to prevent any altered skin integrity, and to apply barrier cream as needed. The physician and family were notified.

Review of a Skin and Wound Evaluation form completed on the date of the incident, indicated an identified altered skin integrity of a measured size was observed on an identified area of the resident’s body. On assessment, discoloration was noted on the identified area of resident #006’s body. No sign or symptom of pain was noted. Barrier cream was applied. Review of a skin care note ten days after the incident indicated that no discoloration or altered skin integrity was observed on the identified area of resident #006’s body, and the skin assessment was discontinued.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Assessment two days after the incident, indicated that resident #006 had an identified altered skin integrity, and was diagnosed with an identified cognitive impairment. The resident required an identified level of care for toileting and perineal care.

Review of the care plan indicated that prior to the CIS incident, resident #006 was to be taken to the washroom for toileting and perineal care, with no specified toileting schedule. There was no specific instruction written in resident #006’s plan of care to direct the staff on safe storage of the identified component of their wheelchair, and removing them from the resident’s wheelchair prior to performing the transfer with mechanical lift.

In an interview, PSW #130 stated that their usual practice before toileting resident #006, was to clean the wheelchair for the resident and place the identified component of the wheelchair on the floor beside the wheelchair. After they finish toileting and transferring the resident to the wheelchair, they would put the identified component back on the resident’s wheelchair. PSW #130 stated that on the day of incident, they had to clean the wheelchair of another resident prior to cleaning resident #006's wheelchair. Due to this change from their regular routine,

PSW #130 had forgotten to go through their usual process of cleaning resident #006's wheelchair and placing the identified component of the wheelchair on the floor that day. When the PSWs took resident #006 out of the washroom after toileting using the identified lift, PSW #130 thought they had already cleaned resident #006’s wheelchair. PSW #130 said they could not find the identified component of resident #006’s wheelchair after transferring resident #006 to their wheelchair, and they were looking for it during their entire shift. PSW #130 acknowledged that they should have checked resident #006’s wheelchair and remove the identified component of the wheelchair from the seating surface of the wheelchair to ensure it was safe, before PSW #131 (their partner) lowered resident #006 to sit on the wheelchair.

In an interview, PSW #131 stated that at the time of the incident, they were operating the identified lift to transfer resident #006 from the washroom to resident #006’s wheelchair inside the resident’s room. PSW #131 stated that after PSW #130 finished the perineal care, they then transferred the resident to the wheelchair which was parked against the wall. PSW #131 said that they did not think of checking the wheelchair first before lowering the resident to sit on it as they were just helping PSW #130, who was the primary PSW, to do the transfer. PSW #131 acknowledged that they should have checked the wheelchair seating surface to ensure it was safe before transferring the resident to sit on the wheelchair.

In interviews, the Director of Care (DOC) stated that the home’s policy did not provide directions to the staff on safe storage of the identified component of the resident’s wheelchair after removing them from residents’ wheelchairs. The DOC acknowledged that PSW #130 and PSW #131 should have checked the seating area of the wheelchair to ensure that it was safe before transferring resident #006 to the wheelchair.

The home has failed to ensure that PSW #130 and PSW #131 used safe transferring techniques when assisting resident #006.

B) CIS report #2663-000008-20 was submitted to the MLTC on an identified date related to an incident involving resident #006. Review of the CIS report and the related incident notes indicated that on the identified date, at an identified time, when agency PSW #140 was pushing resident #006 in wheelchair into their room, the PSW realized that the resident was in pain and discovered that an identified part of resident #006’s body was caught in-between the side of the wheelchair.

The Agency PSW #140 notified the registered staff. The resident was assessed by RPN #139 and appeared to be alert, breathing normally, with no vocalization of pain. When the resident’s identified area of the body was released from the wheelchair, they noticed the resident was grimacing and moaning. The resident sustained an identified injury to the identified area of their body. The family was informed. The resident was sent to the hospital for assessment and returned to the home at a later identified date having received an identified medical procedure in the hospital.

Review of the physician note at a later date indicated that the identified injuries on resident #006’s identified area of the body were healing.

Review of the RAI-MDS Assessment completed prior to the incident indicated that resident #006 had very severe impairment and was at an identified level of care requiring an identified level of assistance for locomotion on unit.

During the inspection, the DOC explained to the inspectors that it was PSW #128 who had pushed resident #006 into the dining room, but resident #006 was on agency PSW #140’s assignment, and PSW #128 was helping agency PSW #140 bring resident #006 to the dining room. Review of the video footage showed that on the identified date of the incident PSW #128 had pushed resident #006 in a tilted position in wheelchair into the dining room, and an identified part of the resident’s body was noted to be on the side of the resident’s wheelchair. After bringing the resident to the front of the table, PSW #128 did not check the position of the identified part of resident #006’s body, and changed the resident’s wheelchair from tilt to upright position. Resident #006 had a sudden jerk of their body with facial grimace. The resident appeared to say something or made some verbalizations, which was heard by PSW #128. PSW #128 then bent down to talk to resident #006, however, the PSW did not appear to notice that the identified part of resident #006’s body was caught in their wheelchair. PSW #128 then left the resident to help serve meals in the dining room. The video showed that resident #006 did not show any further facial grimaces or report any pain to the staff afterwards. Throughout the meal, three staff members were observed sitting down beside resident #006 at different times to provide assistance to the resident. The resident ate their dinner and did not appear to have any discomfort or distress. The resident was seen to be pushed out of the dining room by a staff member after the meal.

According to the CIS, agency PSW #140 transferred resident #006 to their room,

and noticed the resident appeared to be in pain. As per the resident’s progress notes at the time of the incident, agency PSW #140 notified RPN #139, that the identified part of the resident’s body was caught in the wheelchair. Upon coming to the room, RPN #139 saw the identified area of the resident’s body was caught in between the wheelchair. The RPN and PSW tilted the wheelchair back and released the identified part of the resident’s body, and the RPN noticed some bleeding. The RPN performed first-aid treatment, and the resident was sent to the hospital.

In an interview, PSW #128 stated that they had received the training for safety checks during transporting of residents in wheelchairs when they attended the PSW training program at the college. PSW #128 acknowledged that they should have checked to ensure that the identified part of the resident’s body was kept inside the wheelchair before and when they were transporting the resident in the wheelchair to the dining room. They further stated they should have checked the position of the identified part of resident #006’s body before changing the wheelchair from tilt to upright position to ensure the resident’s safety.

In separate interviews, the DOC and the Executive Director (ED) stated that the home had not provided the PSWs with any training on resident safety related to transporting residents in wheelchairs. They expected all PSWs received the above-mentioned training when they attended the PSW training program at the colleges before hiring. They acknowledged that PSW #128 should have checked to ensure that the identified part of resident #006’s body was kept inside the wheelchair before and while pushing the resident in wheelchair, and to ensure the resident was positioned safely before changing the wheelchair back to an upright position.

The home has failed to ensure that PSW #128 used safe positioning techniques when assisting resident #006. [s. 36.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that resident #004 was protected from abuse by resident #003.

A CIS was submitted to the MLTC related to an allegation of abuse between residents #003 and #004, where resident #003 was observed by PSW #105 to exhibit abusive behaviour towards resident #004.

Review of resident #003's care plan at the time showed that the resident had a history of identified responsive behaviours towards an identified type of co-residents. Review of the same care plan showed that the resident was to be monitored at an identified time interval related to the identified responsive behaviour.

Review of resident #004's care plan at the time of the incident showed the resident did not have any responsive behaviours toward co-residents, and did not have any heightened monitoring interventions in place.

Review of the home's investigation notes and resident #003's progress notes and responsive behaviour huddle on the date of the abovementioned incident showed that PSW #105 saw resident #003 exhibit identified responsive behavior towards resident #004 outside of an identified area in the home. Review of the responsive

behaviour huddle showed resident #003 was observed at an identified time prior to the incident, seated in another home area.

Residents #003 and #004 were cognitively impaired, and not interviewable at the time of the inspection.

Interview with PSW #107, resident #003’s assigned PSW on the date of the incident stated they had left the dining room at an identified time to assist other residents with feeding in their rooms, and stated they did not bring resident #003 out of the dining room. The PSW stated the last time they had observed resident #003 was in the dining room at an identified time. PSW #107 stated that resident #003 is usually in an identified home area after meals, but the resident was able to ambulate on their own, and the PSW stated they did not know who had brought resident #003 out of the dining room.

Interview with PSW #105 stated resident #004 usually sits in another identified home area after meals. The PSW stated they had come out of an identified room and came upon the above-mentioned incident between residents #003 and #004 in the identified home area, suspected abuse, and reported the incident to Registered Nurse, RN #117.

Interview with RN #117 who had responded to the incident stated the staff separated residents #003 and #004, and they completed a head to toe assessment for resident #004 after the incident, which showed no injuries. An identified monitoring was provided for resident #003 after the incident. RN #117 further stated that neither resident #003 nor resident #004 were cognitively able to be interviewed at the time of the incident.

During interviews with the ED and DOC, they stated that the identified abuse had occurred for resident #004 during the above-mentioned incident between residents #003 and #004. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the long-term care home protect its residents from abuse by anyone, to be implemented voluntarily.

Issued on this 27th day of May, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care	Ministère 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by IVY LAM (646) - (A1)
Inspection No. / No de l'inspection :	2020_769646_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020698-19, 024068-19, 024110-19, 024192-19, 001321-20, 001648-20, 002114-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 26, 2020(A1)
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

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 # / No d'ordre: 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 O. Reg 79/10, s. 36.

Specifically, the licensee shall ensure that PSWs #128, #130, and #131 and all staff use safe transferring and positioning techniques when assisting resident #006 and all other residents in the home.

Upon receipt of this report the licensee shall:

1. Provide additional training to PSWs #128, #130, #131 and all registered staff and personal support workers who are working on or covering the identified floor, on:

a) Use of safe and proper transferring techniques when transferring residents with the sit-to-stand lift. Ensure that staff perform visual checks of the wheelchair's seating surface before transferring residents to their wheelchairs.

b) Proper storage of the identified wheelchair component in safe locations as designated by the home after removing them from the residents' wheelchairs.

c) Use of safe and proper positioning techniques when transporting residents in
wheelchair to ensure safety.

Maintain the related training records for items a), b), and c) above, including names of those attended, dates, who provided the education and training materials.

2. Develop and implement an on-going auditing process to ensure that:

a) PSW #130 and PSW #131, and all staff working on the identified floor are using safe and proper transferring techniques when transferring residents with the sit-to-stand lift, that staff perform checks of the wheelchair's seating surface before transferring residents to their wheelchairs, and the staff are storing the identified wheelchair components properly in safe locations as designated by the home after removing the identified wheelchair components from residents' wheelchairs.

b) PSWs #128 and all staff working on the identified floor are using safe positioning techniques when transporting residents in wheelchairs to ensure safety.

Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluating the results. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit results.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Personal Support Workers (PSWs) #128, #130, and #131 used safe transferring and positioning techniques when assisting resident #006.

A) Critical incident system (CIS) report was submitted to the Ministry of Long- Term Care (MLTC) related to an incident involving resident #006. Review of the CIS report and the related incident notes indicated that on an identified date, the staff was unable to find an identified component for resident #006's wheelchair. When resident #006 was transferred from wheelchair to bed at an identified time, the staff discovered that the resident had been sitting on the identified component, which was on the seating surface of their wheelchair. The resident had an identified altered skin

integrity on an identified area of their body, which was later resolved. Skin assessment was done immediately and daily since the incident. The resident had not exhibited any pain during assessment. The affected area was cleansed and barrier cream applied. PSWs were educated to change resident's position at identified time intervals to prevent any altered skin integrity, and to apply barrier cream as needed. The physician and family were notified.

Review of a Skin and Wound Evaluation form completed on the date of the incident, indicated an identified altered skin integrity of a measured size was observed on an identified area of the resident's body. On assessment, discoloration was noted on the identified area of resident #006's body. No sign or symptom of pain was noted. Barrier cream was applied. Review of a skin care note ten days after the incident indicated that no discoloration or altered skin integrity was observed on the identified area of resident #006's body, and the skin assessment was discontinued.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Assessment two days after the incident, indicated that resident #006 had an identified altered skin integrity, and was diagnosed with an identified cognitive impairment. The resident required an identified level of care for toileting and perineal care.

Review of the care plan indicated that prior to the CIS incident, resident #006 was to be taken to the washroom for toileting and perineal care, with no specified toileting schedule. There was no specific instruction written in resident #006's plan of care to direct the staff on safe storage of the identified component of their wheelchair, and removing them from the resident's wheelchair prior to performing the transfer with mechanical lift.

In an interview, PSW #130 stated that their usual practice before toileting resident #006, was to clean the wheelchair for the resident and place the identified component of the wheelchair on the floor beside the wheelchair. After they finish toileting and transferring the resident to the wheelchair, they would put the identified component back on the resident's wheelchair. PSW #130 stated that on the day of incident, they had to clean the wheelchair of another resident prior to cleaning resident #006's wheelchair. Due to this change from their regular routine, PSW #130 had forgotten to go through their usual process of cleaning resident #006's wheelchair and placing the identified component of the wheelchair on the floor that

day. When the PSWs took resident #006 out of the washroom after toileting using the identified lift, PSW #130 thought they had already cleaned resident #006's wheelchair. PSW #130 said they could not find the identified component of resident #006's wheelchair after transferring resident #006 to their wheelchair, and they were looking for it during their entire shift. PSW #130 acknowledged that they should have checked resident #006's wheelchair and remove the identified component of the wheelchair from the seating surface of the wheelchair to ensure it was safe, before PSW #131 (their partner) lowered resident #006 to sit on the wheelchair.

In an interview, PSW #131 stated that at the time of the incident, they were operating the identified lift to transfer resident #006 from the washroom to resident #006's wheelchair inside the resident's room. PSW #131 stated that after PSW #130 finished the perineal care, they then transferred the resident to the wheelchair which was parked against the wall. PSW #131 said that they did not think of checking the wheelchair first before lowering the resident to sit on it as they were just helping PSW #130, who was the primary PSW, to do the transfer. PSW #131 acknowledged that they should have checked the wheelchair seating surface to ensure it was safe before transferring the resident to sit on the wheelchair.

In interviews, the Director of Care (DOC) stated that the home's policy did not provide directions to the staff on safe storage of the identified component of the resident's wheelchair after removing them from residents' wheelchairs. The DOC acknowledged that PSW #130 and PSW #131 should have checked the seating area of the wheelchair to ensure that it was safe before transferring resident #006 to the wheelchair.

The home has failed to ensure that PSW #130 and PSW #131 used safe transferring techniques when assisting resident #006.

B) CIS report #2663-000008-20 was submitted to the MLTC on an identified date related to an incident involving resident #006. Review of the CIS report and the related incident notes indicated that on the identified date, at an identified time, when agency PSW #140 was pushing resident #006 in wheelchair into their room, the PSW realized that the resident was in pain and discovered that an identified part of resident #006's body was caught in-between the side of the wheelchair. The Agency PSW #140 notified the registered staff. The resident was assessed by RPN #139 and appeared to be alert, breathing normally, with no vocalization of pain. When the

resident's identified area of the body was released from the wheelchair, they noticed the resident was grimacing and moaning. The resident sustained an identified injury to the identified area of their body. The family was informed. The resident was sent to the hospital for assessment and returned to the home at a later identified date having received an identified medical procedure in the hospital.

Review of the physician note at a later date indicated that the identified injuries on resident #006's identified area of the body were healing.

Review of the RAI-MDS Assessment completed prior to the incident indicated that resident #006 had very severe impairment and was at an identified level of care requiring an identified level of assistance for locomotion on unit.

During the inspection, the DOC explained to the inspectors that it was PSW #128 who had pushed resident #006 into the dining room, but resident #006 was on agency PSW #140's assignment, and PSW #128 was helping agency PSW #140 bring resident #006 to the dining room. Review of the video footage showed that on the identified date of the incident PSW #128 had pushed resident #006 in a tilted position in wheelchair into the dining room, and an identified part of the resident's body was noted to be on the side of the resident's wheelchair. After bringing the resident to the front of the table, PSW #128 did not check the position of the identified part of resident #006's body, and changed the resident's wheelchair from tilt to upright position. Resident #006 had a sudden jerk of their body with facial grimace. The resident appeared to say something or made some verbalizations, which was heard by PSW #128. PSW #128 then bent down to talk to resident #006, however, the PSW did not appear to notice that the identified part of resident #006's body was caught in their wheelchair. PSW #128 then left the resident to help serve meals in the dining room. The video showed that resident #006 did not show any further facial grimaces or report any pain to the staff afterwards. Throughout the meal, three staff members were observed sitting down beside resident #006 at different times to provide assistance to the resident. The resident ate their dinner and did not appear to have any discomfort or distress. The resident was seen to be pushed out of the dining room by a staff member after the meal.

According to the CIS, agency PSW #140 transferred resident #006 to their room, and noticed the resident appeared to be in pain. As per the resident's progress notes at the time of the incident, agency PSW #140 notified RPN #139, that the identified part

of the resident's body was caught in the wheelchair. Upon coming to the room, RPN #139 saw the identified area of the resident's body was caught in between the wheelchair. The RPN and PSW tilted the wheelchair back and released the identified part of the resident's body, and the RPN noticed some bleeding. The RPN performed first-aid treatment, and the resident was sent to the hospital.

In an interview, PSW #128 stated that they had received the training for safety checks during transporting of residents in wheelchairs when they attended the PSW training program at the college. PSW #128 acknowledged that they should have checked to ensure that the identified part of the resident's body was kept inside the wheelchair before and when they were transporting the resident in the wheelchair to the dining room. They further stated they should have checked the position of the identified part of resident #006's body before changing the wheelchair from tilt to upright position to ensure the resident's safety.

In separate interviews, the DOC and the Executive Director (ED) stated that the home had not provided the PSWs with any training on resident safety related to transporting residents in wheelchairs. They expected all PSWs received the above-mentioned training when they attended the PSW training program at the colleges before hiring. They acknowledged that PSW #128 should have checked to ensure that the identified part of resident #006's body was kept inside the wheelchair before and while pushing the resident in wheelchair, and to ensure the resident was positioned safely before changing the wheelchair back to an upright position.

The home has failed to ensure that PSW #128 used safe positioning techniques when assisting resident #006. [s. 36.]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #006. The scope of the issue was a level 1 as it related to one of five residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Compliance order (CO) issued September 21, 2017, with a compliance due date of November 30, 2018 (2017_646618_0015)
- Voluntary plan of correction (VPC) issued April 10, 2019 (2019_650565_0005)
- Compliance order (CO) issued October 1, 2019, with a compliance due date of October 31, 2019 (2019_808535_0013)

Additionally, the LTCH has a history of six other compliance orders in the last 36 months. (726)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2020(A1)

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 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 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 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 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 27th day of May, 2020 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by IVY LAM (646) - (A1)

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