Ontario

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

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

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	TAMMY SZYMANOWSKI
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	012501-21, 012545-21, 012599-21
Original Inspection #:	2021_792659_0022
Licensee:	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home:	The Village of Winston Park 695 Block Line Road, Kitchener, ON, N2E-3K1
Name of Administrator:	Brad Lawrence

Background:

Ministry of Long-Term Care (MLTC) Inspector #659 conducted a complaint inspection at The Village of Winston Park (the Home) on November 1, 3, 4 and 5, 2021. Intake logs (#012501-21, 012545-21, 012599-21) were inspected during the inspection.
Based on the inspection, the Inspector determined that the Licensee, Schlegel Villages Inc. (the Licensee), failed to comply with s. 36 of Ontario Regulation 79/10 (Regulation) under the Long-Term Care Homes Act, 2007 (LTCHA).
Pursuant to s. 153(1)(a) of the LTCHA, the Inspector issued the following compliance order (CO #001) for the non-compliance finding:

The licensee must comply with O. Reg. 79/10 s. 36.

Specifically, the licensee must ensure that:

1. Safe techniques are used when transferring/portering residents in wheelchairs.

2. The falls prevention program is reviewed and revised to include best practice for portering of residents in wheelchairs.

3. Safe portering techniques are added to residents' plans of care where appropriate.

4. Re-education of all staff is completed in relation to the updated falls prevention program, with focus on portering residents and application of footrests to wheelchairs. The record should be kept in the home including: the name of the person providing the education, information reviewed, the date of the education, signature of persons attending the education.

Following a review of CO #001 by the Director, CO #001 has been altered and substituted with the Director's Order below.

Order #:	001

To **Schlegel Villages Inc.**, you are hereby required to comply with the following order by the date set out below:

Pursuant To:

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:

The licensee must be compliant with s. 36 of the Regulation and ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Specifically, the licensee must ensure that:

1. Safe devices or techniques are used when transferring residents, including portering residents in wheelchairs.
2. PSW #103 receives an individual review of the incident and a review of the use of footrests and transfers for residents in order to advance self-learning of the staff and prevent re-occurrence. A record of this review, including who participated and what was reviewed, should be kept.
3. For residents who are assessed with the ability to self-propel in their wheelchairs, clear direction is provided to staff for when to apply or remove the use of footrests.

Grounds:

The licensee has failed to ensure staff used safe transferring and positioning devices or techniques when assisting resident #001.

Resident #001 was being portered from the dining room to their room by PSW #103. At the time, there were no footrests attached to the wheelchair. The resident put their feet down on the ground stopping movement and proceeded to stand for approximately 10 seconds before falling forward. The resident sustained significant injury and passed away in hospital the next day.

Physiotherapy and kinesiologist assessments indicated that the resident had been more tired, less physically able, and required extensive assistance of two staff to assist with transfers. When the resident stopped the wheelchair, PSW #103 stated that the resident began to lift their bottom as if to reposition or stand. At this time there is no indication that the PSW moved from behind the wheelchair to assist the resident in repositioning or transferring. The PSW further stated that they noticed the resident was about to stand as they put their hands on either side of the handles and that the resident stood for at least 10 seconds. The PSW said that it was enough time for them to ask the resident what they were doing.

The PSW shared with the inspector that the resident started falling forward and they tried to grab the resident; however, they could not grasp them and the resident fell forward. When PSW #103 started to notice the resident attempting to stand and the 10 second duration the resident was standing, PSW #103 did not reinforce assistance by instructing the resident to remain sitting until assistance could be provided but rather asked the resident what they were doing. Nor did the PSW move into a position to provide effective assistance in the resident's spontaneous transfer.

Based on the physiotherapy assessment of resident #001's balance and bilateral hip extension for leg range of motion and strength, resident #001 would have had difficulty holding their feet up to be portered and should have had footrests applied to provide safety and comfort. The lack of footrests did contribute to the incident as it is reasonable to conclude that if footrests were applied when PSW #103 was portering the resident, that the resident would not have been able to place their feet on the ground to stop the wheelchair which then lead to the attempt to transfer.

Failing to provide safe transferring and positioning devices or techniques when assisting resident #001 had resulted in actual harm to the resident.

Main sources: resident #001 and #005's plan of care and clinical records, interviews with PSWs RPN #104, RN #102, DOC and Kinesiologist.

An order was made by taking the following factors into account:

Severity of non-compliance: There was actual harm to resident #001 by not providing safe transferring and positioning devices or techniques when assisting the resident. This was particularly the case when resident #001 did not have footrests applied to their wheelchair nor receive assistance to transfer when the wheelchair was stopped. By not doing so, the resident sustained significant injuries and passed away in hospital the next day.

Scope of non-compliance: The scope of the non-compliance was isolated because one of four residents reviewed during the inspection did not receive safe transferring and positioning devices or techniques.

Licensee's compliance history: The licensee has had previous findings of non-compliance, including three written notifications and four voluntary plans of correction in the last 36 months, under different subsections of the LTCHA.

This order must be complied with by:	January 27, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
438 University Avenue, 8th Floor
Toronto ON M7A 1N3
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.

Issued on this 13th day of January, 2022	
Signature of Director:	
Name of Director:	TAMMY SZYMANOWSKI