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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2019	2019_810654_0005	007667-18, 010713-18, 011192-18, 018852-18, 011391-19	Critical Incident System

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 Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

SIMAR KAUR (654), JOANNE ZAHUR (589), JULIEANN HING (649)

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 27, 28, 29, 30, and September 04, 05, 06, 09, 10, 11, 12, 13, 16 and 17, 2019.

The following intakes were completed during this inspection:

-Log #007667-18, CIS #2888-000022-18; Log #011192-18, CIS #2888-000033-18; and Log #011391-19, CIS #2888-000020-19- were related fall resulted in an injury.
-Log #010713-18, CIS #2888-000031-18; and Log #018852-18, CIS #2888-000038-18- were related to alleged abuse.

PLEASE NOTE: A Written Notification and Volunteer Plan of Correction related to LTCHA, 2007, s. 6. (7), s. 6 (10) b, identified in a concurrent inspection #2019_810654_0004 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS), Personal Care Provider (PCP), Registered Nurse (RN), Registered Practical Nurse (RPN), Resident Care Coordinator (RCC), Private Caregiver (PC), Physiotherapist (PT), Staff Educator, and Residents.

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
2 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	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 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 :

1. The licensee has failed to ensure that residents #003 and #005 were protected from physical abuse.

A Critical Incident System (CIS) report was reported to the Ministry of Long-Term Care (MLTC), related to an incident of resident to resident physical abuse that occurred on an identified date. According to the CIS report resident #003 was physically abused by resident #001 in a specified resident home area.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

According to the CIS report, resident #003 sustained identified injuries and was transferred to the hospital for further assessment. The resident returned to the home with no new orders.

Resident #001 was transferred to hospital for further assessment after the above incident and was no longer a resident in the home at the time of the inspection.

A review of residents #001 and #003's progress notes prior to the above incident did not indicate any previous history of responsive behaviours between these residents. Record review indicated the above incident had happened suddenly and was unprovoked.

Staff and private caregiver interviews indicated that the altercation between residents #001 and #003 had started at the above specified resident home area. The altercation between these two residents was captured on the home's video surveillance, however this footage was not available to the inspector at the time of the inspection.

In an interview with private caregiver #101 who had witnessed the incident told the inspector that residents #001 and #002 were sitting together outside of the home and resident #003 was by themselves in the above specified home area. Resident #001 suddenly started to attack resident #003 who was bent over during the attack to protect themselves. According to the private caregiver resident #003 tried to run away from resident #001 but they followed them into another identified home area and continued to attack them. The private caregiver told the inspector they had not seen residents #001 and #003 interacting with each before the incident.

In an interview with resident #002 who was with resident #001 when the incident suddenly occurred, told the inspector that they did not know why resident #001 had suddenly attacked resident #003. Resident #002 abruptly ended the interview with the inspector citing that it was upsetting for them.

In an interview with resident #003, they remembered being attacked by resident #001 and told the inspector they were looking at them when they suddenly attacked them. Resident #003 told the inspector they were afraid of resident #001 and felt scared and unsafe.

In an interview with the DOC, they acknowledged that physical abuse had occurred as resident #003 sustained injuries during the altercation they had with resident #001.

2. A CIS report was submitted to the MLTC, related to an identified injury of unknown cause to resident #005's identified body part. On an identified date, an x-ray report indicated that resident #005 sustained an identified injury.

A review of resident #005's progress notes indicated there was a previous CIS report submitted to the MLTC, related to an allegation of visitor to resident physical abuse. According to the CIS report Personal Care Provider (PCP) #137 witnessed resident #005 and an identified family member crossing the street and had observed the resident's family member physically abuse the resident. According to the CIS report, the DOC spoke with the resident who denied the allegation. The DOC spoke with the resident's above identified family member who denied the allegation of physical abuse.

Further review of a progress note dated on an identified date indicated that the resident reported to two registered staff that their above identified family member had physically abused them and that they had done it on and off over the last few weeks, because they

were not perfect. The resident was asked if they were physically abused by the identified family member on the same day and they told staff that they were.

According to resident #005's progress notes as a result of the above incident, the home advised another specified family member, who agreed that the resident's identified family member will only visit the resident with another family member present.

According to a progress note dated on an identified date, resident #005's above identified family member had visited them unsupervised at an identified time and remained in an identified home area with the resident during a meal service.

According to a progress note dated on another identified date after the above mentioned visit indicated that resident #005 was found to have altered skin integrity on their above identified body part.

Another progress note indicated that resident #005 complained of pain to their identified body part to PCP #118, who inquired with the resident if anyone had hurt them; the resident responded yes and named their above identified family member.

Resident #005 was not interviewable during the inspection due to cognitive impairment.

During an interview PCP #118 told the inspector they had asked the resident how they hurt their identified body part, and the resident told them that it was their identified family member.

In an interview with PCP #119 who had been working with the resident since their admission to the home, they told the inspector that they had observed the resident's above identified family member agitated and abrupt with the resident approximately one year ago but had since noticed an improvement. When the PCP was asked if the identified family member massages the resident's above identified body part, they responded that they did, and explained that they had reported to the home as they were quite rough. They further explained that instead of just massaging the resident's identified body part they would squeeze a bit harder on identified body parts and had observed finger prints in these areas.

In interviews with RPN #110, RCC #122, and ADOC #133 they all acknowledged that based on the above, mentioned definition that physical abuse toward resident #005 had occurred since the resident had reported that their identified family member had

physically abused them resulting in above identified injury.

3. The licensee has failed to ensure that resident #005 was not neglected by the licensee or staff.

A CIS report was submitted to the MLTC, related to an identified altered skin integrity of unknown cause on resident #005’s identified body part. An x-ray report indicated that resident #005 sustained an identified injury on the above identified body part.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “neglect means” the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Record review indicated upon the initial discovery of the identified altered skin integrity on an identified date the resident had complained of soreness when asked by RPN #110 to perform range of motion (ROM). According to the RPN’s assessment swelling was observed, the resident was administered an identified medication, and another identified treatment was applied. A pain assessment completed indicated pain was minor. The resident was unable to say how they had sustained the identified altered skin integrity. According to a later progress note indicated that resident #005’s identified family member approached RPN #110 and reported that the resident did not seem their usual self. The RPN documented that the resident was noted to be pale and lethargic, vitals signs were checked, and the resident was transferred to bed. No further action was completed at this time.

A review of progress notes dated on the above identified date indicated that RCC #123 had been informed of resident #005’s identified altered skin integrity and they were informed by RPN regarding the redness and soreness on the resident’s identified body part. They documented no swelling was noted, and a message was left for the resident’s identified family member. There was no documentation by the RCC of any action taken when they became aware of the resident’s identified altered skin integrity.

Further review indicated on the above identified date, the resident had remained in bed during the shift. They appeared anxious, was complaining they could not breathe, and had refused oxygen via nasal prongs. Despite these changes no documentation of any action or further assessment was taken regarding the resident’s above identified altered skin integrity, swelling, and soreness with ROM.

According to another progress note, it was documented on the night shift that the resident did not sleep well, and an identified medication was administered. There was no documentation of a reassessment completed.

A review of progress notes indicated that the above identified altered skin integrity on the identified body part of the resident was getting larger and was purplish in color. The resident did not complain of pain. The resident's above identified family member visited them and was upset that their identified altered skin integrity had worsened and requested to have the resident seen by a physician. According to the progress note, the family member was told there was no physician in the home, and they decided to take the resident to hospital to have an x-ray done. The resident returned from hospital the same day with a new treatment for their above identified body part. The family member verbally informed the home that the resident had been diagnosed with an identified injury to the above identified body part.

Record review indicated an identified hospital's diagnostic report, that resident #005 had above identified injury.

Resident #005 was not interviewable during the inspection due to cognitive decline.

In an interview with RPN #110, they told the inspector that in hindsight they should have sent the resident to the hospital.

In an interview with RCC #123, they told the inspector that they had assessed the resident on the identified date and indicated there was no swelling but was unaware of the resident having difficulty with ROM due to soreness. When the inspector further questioned if they had completed an assessment of the resident, they responded that they could not remember. There was no documentation of an assessment completed by RCC #123 of resident #005's identified skin integrity when it was reported to them.

In an interview with RCC #122, they told the inspector in response to what action should have been taken by the home when resident #005 was first identified with the identified altered skin integrity, they indicated that if the resident was having pain with ROM the physician should have been called for an x-ray. RCC #122 confirmed based on the above definition that neglect had occurred.

Resident #005 was identified with the above identified altered skin integrity of unknown

cause on the identified body part, there was documentation of soreness with ROM and swelling, no action or further assessment was taken by the home until the resident's identified family member asked for the resident to be seen by the physician. The family member took the resident to hospital for an x-ray which confirmed the above identified injury, this indicates a pattern of inaction by the home.

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff had used safe transferring and positioning devices or techniques when assisting resident #011, #012 and #013.

A CIS report was submitted to the MLTC, related to resident #011's fall resulting in an injury.

Review of the CIS report indicated that resident #011 had a fall on an identified date and time, the resident was found on the floor on an identified resident home area. Upon assessment the resident complained of pain in an identified body part, and swelling was noted on their identified body parts. The resident was transferred to the hospital and returned the same day with the diagnosis of an identified injury.

Review of the resident's plan of care indicated that they required identified assistance from staff with transfer and toileting.

Review of resident #011's progress notes on the above identified date, indicated that the resident was found on the floor on the identified resident home area and a PCP then transferred the resident to the bed.

Review of the home's investigation notes of an interview conducted with PCP #107, indicated that the resident was found on the floor on the identified resident home area by the PCP. The PCP then transferred the resident to bed on their own prior to the resident being assessed by a registered staff. The notes further indicated that RPN #103 had gone to another unit, and the PCP could not reach them when they had called after finding the resident on the floor.

Further review of the home's investigation notes and interview with staff educator #104 indicated that PCP #107 was provided with education on the home's Personal Support Worker (PSW) Guidebook under the falls section, after the incident mentioned above. Review of the guidebook, titled: Nursing Procedures, under the fall section indicated as follows:
-In an event of a fall PSWs to report to registered staff immediately, and
- Do not attempt to move the resident until they have been assessed by a registered staff.

Interview with resident #011 indicated that they could recall the above mentioned fall incident. The resident explained that they fell facing down on the floor on the identified resident home area. PCP #107 had hurt their identified body part while manually lifting them up holding them while standing behind their back. They further explained that the PCP had put both of their arms underneath their shoulders and manually lifted them up from the floor. They told the PCP to stop as it was causing them pain, and they did not stop.

Interview with RPN #103 indicated that PCP #107 had notified them of the resident's fall after they fell on the identified date. The resident was already transferred to bed when the RPN went to assess them after the fall. The RPN further explained that as per the home's expectations after each fall, residents should be assessed by a registered staff prior to moving them, and at least two staff should assist the resident to prevent any further injuries. The RPN further stated that this was not done for resident #011.

Interview with PCP #107 indicated that they found the resident on the floor on the identified date. They called RPN #103 on their pager and could not reach them. They went ahead and manually lifted the resident to bed without assistance from another staff, prior to being assessed by the registered
staff. PCP acknowledged the resident should have been assisted by two PCPs and was required to be assessed by a registered staff after the fall and prior to the transfer to bed.

Interview with the DOC indicated that after the fall, the resident should have been assessed by a registered staff prior to being transferred by a PCP, and two staff should have assisted the resident with the transfer from floor to bed. PCP #107 did not use safe transferring techniques when they had transferred resident #011 from the floor after the fall.

2. Resident #012 and #013 were used to expand the resident sample size due to non-compliance found for resident #011.

(A) During an observation on an identified date, inspector observed resident #012 being transferred from bed to their wheelchair by PCPs #116 and #146. An identified transfer device with an identified size of transfer equipment was used by the PCPs to transfer the resident. A transfer logo was observed in the resident's room indicating to use a different size of transfer equipment for mechanical transfer.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) identified that resident #012 required specific assistance with specific number of staff members, using the identified transfer device.

Record review of resident #012's transfer and lift assessment and plan of care indicated the resident should be transferred using the above identified transfer device with a specified size of transfer equipment, with specific number of staff members.

Separate interviews with PCP #116 and #118 indicated they used an identified different size of transfer equipment during resident #012's mechanical transfer. They confirmed that the resident was required to be transferred using the above specified size of equipment as indicated on their transfer logo. PCP #116 indicated they could not find the above specified size of transfer equipment in the resident's room and had used the one they could find.

(B) During another observation on the identified date resident #013 was observed being transferred from bed to their wheelchair by PCP #148 and RPN #147. An identified transfer device with an identified size of transfer equipment was used by the PCP and RPN to transfer the resident. A transfer logo was observed in the resident's room indicating to use a different size of transfer equipment for mechanical transfer.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) identified that resident #013 required specific assistance with specific number of staff members,

using the identified transfer device.

Record review of the resident #013's transfer and lift assessment and plan of care indicated, the resident should be transferred using the identified transfer device with a specified size of transfer equipment, with specific number of staff members.

In separate interviews with PCP #148 and RPN #147 they indicated that a different size of transfer equipment was used during resident #013's mechanical transfer. They confirmed that the resident was required to be transferred using the above specified size of equipment as indicated on their transfer logo. PCP #148 indicated that the different size of transfer equipment was already in the resident's room and they did not verify the equipment size with their transfer logo prior to using it.

Interview with RPN #147 indicated that PCPs and registered staff both were responsible to ensure that the right size of transfer equipment was used prior to transferring any resident when using the identified transfer device. Using the wrong size of transfer equipment could put residents at potential risk for injury.

A review of the home's policy titled, Mechanical Lifts and Resident Transfers (LTC-CA-WQ-200-0712), last revised July 2019, identified that the identified transfer equipment required to be visibly inspected prior to use.

Review of the identified transfer equipment sizing manufacturer's guide used by the home titled Tollos product guide, identified a specific size of transfer equipment to be used for weight between 75-124 Pounds (lbs)/ 34- 56.2 Kilograms (kgs). A warning on the guide indicated that failure to use the appropriate size and type can result in serious injury.

During interview with RCC #122, they reviewed the transfer equipment sizing guide and indicated that for residents' weight between 34- 56.2 Kilograms (kgs) the above specified size of transfer equipment should be used for mechanical transfers. The RN reviewed both residents' weights and indicated that resident #012 and #013's current weights were between the above mentioned weight range. By using the different size of transfer equipment staff did not follow the home's sling sizing guide.

Interview with the ADOC #133 indicated that staff were responsible to check the residents transfer equipment size to ensure that it matched with their transfer logo posted in residents' rooms and plan of care. Staff did not use safe transferring devices when

transferring resident #012 and #013 from bed to wheelchair.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the care set out in the plan of care was provided to residents #011, #014, #029, and #050 as specified in the plan.

A CIS report was submitted to the MLTC, related to resident #011’s fall resulting in an injury.

Review of resident’s plan of care indicated high risk for falls. Fall prevention interventions indicated that the resident had an identified intervention.

During resident observations on an identified date, the above identified intervention was not observed in place for resident #011.

Interview with the resident indicated that they never had the identified intervention in place.

Interview and observation of the resident's room with RPN #105, and PCP #106 indicated that the resident did not have the identified intervention on the identified date. PCP #106 further indicated that they worked with the resident on five other identified dates in 2019, and the resident did not have the identified intervention in place.

Interview with RPN #105 and ADOC #133 indicated that resident #011 should have the above identified intervention as per their plan of care. [s. 6. (7)]

2. A CIS report was submitted to the MLTC, for a fall incident involving resident #050. The CIS report indicated resident #050 was transferred to hospital and diagnosed with an identified injury as a result of a fall.

A review of resident #050’s health record indicated they were at high risk for falls. A review of the care plan before and after the above-mentioned fall under the fall focus indicated; the use of a specified falls prevention and management equipment as one of the fall prevention strategies to be in place.

A review of the assessment tab in Point Click Care (PCC) indicated that resident #050 sustained further falls after the above identified fall incident.

A review of the post falls analysis completed for a fall incident on an identified date, indicated that resident #050 was found on the floor in an identified resident home area without the above mentioned specified falls prevention and management equipment.

During an interview, PCP #132 stated on the identified date, they were portering residents to the dining room for lunch when they found resident #050 on the floor and noted they did not have the above mentioned specified falls prevention and management equipment in place. PCP #132 further stated they were not resident #050’s primary caregiver that day, that it was PCP #134. PCP #132 also stated they had informed RPN #124 that the specified falls prevention and management equipment were not in place for resident #050.

During an interview, PCP #134 stated they were resident #050’s primary caregiver and that there had been a couple of occasions where they had not applied the above specified falls prevention and management equipment on resident #050 because they were not available. PCP #134 could not recall if the above identified day, was one of those days.

During an interview, RPN #124 stated they were not aware that the above specified falls prevention and management equipment had not been in place for resident #050 until it was reported to them by PCP #132. RPN #124 further stated that if a resident requires the above specified equipment and none are available, the PCP is to inform them, and they will get it from the RCC.

During an interview, RN #108 acknowledged the inspector's findings that the care set out in the plan of care had not been provided to resident #050 as specified in their plan. [s. 6. (7)]

3. An anonymous complaint was submitted to the MLTC, related to residents not being provided with continence care.

Resident #014 and #029 were used to expand the sample size.

Review of both resident's current plan of care indicated that they required specific assistance with specific number of staff members to provide specific incontinence care in bed.

Interview with PCP #116 indicated they work part time nights with both residents, and there is only one PCP on their unit during the night shift. They indicated that they had been providing the above specified incontinence care by themselves during the night shift for an identified time period. The PCP further stated that by calling a PCP from another unit they would be wasting their time, as both residents were not heavy for them. They explained that the PCP on the opposite unit had their own workload to complete on night shifts.

Interview with PCP #115 indicated that they work on the opposite unit on nights with PCP #116. They indicated that PCP #116 did not call them to assist with residents #014 and #029 on night shifts. They further indicated that the night RPN #114 may have assisted the PCP #116 with the resident's care if they asked.

Interview with RPN #114, working full time night shifts indicated that PCP #116 did not call them to assist the above mentioned residents with continence care during night shifts.

Interview with ADOC #133 indicated that PCPs were required to follow the residents'

plans of care and resident #014 and #029 should have been assisted by above specified number of staff members during nights to provide the specified incontinence care. [s. 6. (7)]

4. The license has failed to ensure that resident #009 was reassessed and the plan of care reviewed and revised when their needs change or the care set out in the plan of care was no longer necessary.

An anonymous complaint was submitted to the MLTC, related to concerns with the implementation of falls prevention interventions.

During an observation on an identified date, with RPN #112 between an identified time period during a night shift, and with PSW #137 between another identified time period on an identified resident home area, resident #009 was observed in bed without a specific falls prevention and management equipment in place.

According to resident #009's care plan under the falls focus indicated that the resident was at high risk for falls and required the specified falls prevention and management equipment in place for safety.

In an interview with PSW #137, they acknowledged they did not observe resident #009 using the above specified falls prevention and management equipment in place during the above mentioned observation and told the inspector that the resident did not get out of bed. RPN #112 told the inspector that resident #009 was not at high risk for falls.

In an interview with RAI- MDS coordinator #138, they told the inspector that the resident had no falls since their admission in the home but was considered a high risk for falls as they had fallen prior to moving into the home; that was why the above specified falls prevention and management equipment were implemented as a fall intervention. The resident did not require the specified equipment as they were not restless in bed and that the resident's care plan indicating they were at a high risk for falls was not accurate. The RAI- MDS coordinator told the inspector that the resident's care plan should be updated at their next RAI-MDS assessment review and should be changed to a low risk for falls.

In an interview with ADOC #133 they explained that if this intervention was not needed it should be removed and the resident's care plan should be updated. [s. 6. (10) (b)]

5. The licensee has failed to ensure that resident #005 was reassessed and their plan of

care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

A CIS report was submitted to the MLTC, related to an altered skin integrity of unknown cause that was first identified on an identified date, on resident #005’s specified body part. An x-ray report indicated that resident #005 had sustained an identified injury.

A review of resident #005’s progress notes indicated there was a previous CIS report submitted to the MLTC, related to an allegation of visitor to resident physical abuse. According to the CIS report Personal Care Provider (PCP) #137 witnessed resident #005 and an identified family member crossing the street and had observed the resident’s family member physically abused the resident. According to the CIS report, the DOC spoke with the resident who denied the allegation. The DOC spoke with the resident’s family member who denied the allegation of physical abuse.

According to resident #005’s progress notes as a result of the above incident, the home advised another identified family member, who agreed that the resident’s identified family member will only visit the resident with another family member present.

According to a progress note dated on an identified date, resident #005’s identified family member had visited them unsupervised at an identified time and remained in an identified home area with the resident during a meal service.

Another progress note dated on another identified date indicated that resident #005’s identified family member had visited them at an identified time unsupervised. They remained in a specific resident home area with the resident and was noted leaving the area with the resident to go downstairs.

On both occasions mentioned above when resident #005’s identified family member visited them unsupervised there was no documentation of any action taken by the home. The inspector was unable to locate this intervention in the resident’s written plan of care.

RPN #110 who documented the two above unsupervised visits of resident #005’s identified family told the inspector that they had approached them and reminded them about the supervised visits but could not force them to leave. The RPN further explained that a skin assessment is completed on the resident after every visit from their identified family member and they are monitored during visits.

In an interview with RCC #122, they acknowledged that the resident's plan of care had not been followed when the resident's identified family member had visited them on the above two mentioned dates unsupervised.

In an interview with ADOC #133, acknowledged that the plan of care should have been reviewed or revised when the resident's identified family member visited them on the above mentioned dates, unsupervised to include supervised visits. [s. 6. (10) (c)]

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 care set out in the plan of care is provided to the residents as specified in the plan, and the resident is reassessed and the plan of care reviewed and revised, when their care needs change or the care set out in the plan of care is no longer necessary; or the care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 and #050's specified falls prevention and management equipment were maintained in a safe condition and in a good state of repair.

A CIS report was submitted to the MLTC related to resident #011’s fall resulting in an injury.

Review of resident’s plan of care indicated high risk for falls. Interventions indicated that the resident should have the above mentioned specified falls prevention and management equipment on their mobility device.

During resident observations on an identified date, the above mentioned specified falls prevention and management equipment was observed not attached to the resident’s mobility device. However, the equipment was noted at the back of their mobility device in a mesh bag. The inspector observed RPN #105 who took the specified equipment out of the bag and found that it was not functioning.

During an observation and interview with RPN #105 they confirmed that the resident’s above specified falls prevention and management equipment was not working on the identified date. The RPN then proceeded and replaced the specified equipment with a working one.

Interview with the ADOC #133 indicated that the above mentioned specified equipment were used as a fall prevention management equipment by the home and should always be maintained in a good state of repair.

2. A critical incident system (CIS) report was submitted to the MLTC, for a fall incident involving resident #050.

A review of resident #050’s health record indicated they were at high risk for falls. A review of the care plan after the above-mentioned fall indicated under the fall focus; to use a specified falls prevention and management equipment as one of the fall prevention strategies to be in place.

A review of the assessment tab in Point Click Care (PCC) indicated that resident #050 sustained further falls after the above mentioned fall incident. A review of the post falls analysis completed for a fall incident on another identified date indicated the above mentioned specified falls prevention and management equipment was not working and required a new battery.

During an interview, PCP #134 stated they had been resident #050’s primary caregiver

for approximately the past two months. PCP #134 further stated they could not recall whether the above mentioned specified equipment was not functioning on the identified date, however, they were aware of reporting to the registered staff if it was not functioning.

A review of the daily staffing roster for the identified date, indicated that PCP #134 was working that day on resident #050’s resident home area (RHA).

During a conversation, RPN #124 stated they had not been informed that resident #050’s above mentioned specified equipment had not been functioning on the identified date. RPN #124 further stated they had become aware after the fall incident that the equipment required a new battery.

During an interview, RN #108 acknowledged that resident #050’s above mentioned specified falls prevention and management equipment had not been maintained in a safe condition and in a good state of repair.

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On an identified date and time, the inspector observed the screen on a point of care (POC) terminal outside of resident room #407 to be open, and an identified resident s personal health information was visible.

In an interview with PCP #111, they told the inspector they were documenting at this terminal and the screen had frozen. Inspector inquired what they should do when the screen freezes and they responded that they should reboot the terminal. The inspector observed the PCP rebooting the POC terminal and the PCP acknowledged that the POC screen should not have been left open when not in use.

On another identified date and time, the inspector observed the eMAR screen on a medication cart open on an identified resident home area. The medication cart was parked across from the nursing station in the hallway. The nurse was observed in the TV room and a resident on a mobility device was observed close to the e-MAR screen on the medication cart.

In an interview with RPN #135 they acknowledged that the e-MAR screen should not have been left open when unattended.
In an interview with ADOC #133, they explained that staff are expected to ensure that the POC and e-MAR are locked when unattended to ensure no personal health information is being shared.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put any strategy in place, that the strategy was complied with for resident #050.

A CIS report was submitted to the MLTC, for a fall incident involving resident #050. The CIS report indicated resident #050 was transferred to hospital and was diagnosed with an identified injury as a result of this fall.

In accordance with O. Reg. 79/10, s.48 (1) 1 and in reference to O. Reg. s. 49 (1), the licensee was required to have a Falls Prevention and Management Program that provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's falls policy "Resident Falls Prevention Program- #LTC-CA-WQ-200-07-08, revised June 2019, as part of their Falls Prevention and Management Program which required staff to apply a specified visual identifier for residents with a specific number of scores on an identified fall risk assessment.

A review of the assessment tab in Point Click Care (PCC) indicated another identified fall risk assessment had been completed, after the above-mentioned fall incident which indicated resident #050 was at high risk for fall. Most recently, the LTCH introduced the identified fall risk assessment and this was completed on another identified date, which also indicated that resident #050 remained at high risk for falls.

Observations conducted on an identified date and shift by the inspector, indicated there was no above specified visual identifier in place for resident #050 as per the licensee’s policy for residents with a specific number of scores on an identified fall risk assessment

tool.

During an interview with RPN #124 next day after the above identified observation, they stated that a specified visual identifier was applied to resident #050's room door and mobility device the previous evening as they were at high risk for falls.

During an interview, RN #108, who is also the falls prevention program lead in the long-term care home (LTCH) stated that staff had not applied the above specified visual identifier when resident #050's above identified falls risk assessment indicated a high risk for falls. RN #108 acknowledged that the staff had not complied with the licensee's policy regarding the use of the above specified visual identifier.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused injury to resident #004 for which they were taken to hospital and results indicated a significant change in the resident's health condition.

A CIS was submitted to the MLTC, for an incident involving resident #004 who sustained a fall on an identified date and was transferred to hospital. The resident returned to the home next day, with a diagnosis of an identified injury to a specified body part.

In an interview with the DOC, they acknowledged that the home submitted the CIS report to the Director on an identified date, two days after they became aware of the resident's above identified diagnosis.

The home had failed to inform the Director of the incident involving resident #004 no later than one business day when the resident had returned to the home, with the above identified diagnosis.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The license has failed to ensure that all areas where drugs were stored shall be kept locked at all times, when not in use.

On an identified date and time, the inspector observed a medication cart unlocked on a specified resident home area. The medication cart was parked across from the nursing station in the hallway. The nurse was observed in the TV room and a resident on a specified mobility device was observed close to the unlocked medication cart.

In an interview with RPN #135 they acknowledged that the medication cart should have been locked when they left it unattended, and explained they were trying to get to a resident.

In an interview with ADOC #133, they explained that this incident was taken very seriously and nursing staff are aware to lock the medication cart at all times when not in use.

Issued on this 30th 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

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

Ministère 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) : SIMAR KAUR (654), JOANNE ZAHUR (589), JULIEANN HING (649)

Inspection No. / No de l'inspection : 2019_810654_0005

Log No. / No de registre : 007667-18, 010713-18, 011192-18, 018852-18, 011391-19

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 16, 2019

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 Woodhaven Long Term Care Residence
380 Church Street, MARKHAM, ON, L6B-1E1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Belisha Ke

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA 2007.

Specifically the licensee must:

1. Complete head to toe assessments for resident #005 after every visit from an identified family member. A record of these assessments must be maintained.

2. Ensure that investigations are conducted for incidents where residents are identified with significant injury/ bruise, to determine the cause. Documentation of investigation notes must be maintained.

3. Residents identified with significant injury/ bruise of unknown cause should receive an assessment by the registered staff in collaboration with RCC on the shift it is identified. Documentation of these assessments must be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #003 and #005 were protected from physical abuse.

A Critical Incident System (CIS) report was reported to the Ministry of Long-Term Care (MLTC), related to an incident of resident to resident physical abuse that occurred on an identified date. According to the CIS report resident #003 was physically abused by resident #001 in a specified resident home area.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

According to the CIS report, resident #003 sustained identified injuries and was transferred to the hospital for further assessment. The resident returned to the home with no new orders.

Resident #001 was transferred to hospital for further assessment after the above incident and was no longer a resident in the home at the time of the inspection.

A review of residents #001 and #003's progress notes prior to the above incident did not indicate any previous history of responsive behaviours between these residents. Record review indicated the above incident had happened suddenly and was unprovoked.

Staff and private caregiver interviews indicated that the altercation between residents #001 and #003 had started at the above specified resident home area. The altercation between these two residents was captured on the home's video surveillance, however this footage was not available to the inspector at the time of the inspection.

In an interview with private caregiver #101 who had witnessed the incident told the inspector that residents #001 and #002 were sitting together outside of the home and resident #003 was by themselves in the above specified home area. Resident #001 suddenly started to attack resident #003 who was bent over during the attack to protect themselves. According to the private caregiver resident #003 tried to run away from resident #001 but they followed them into another identified home area and continued to attack them. The private caregiver told the inspector they had not seen residents #001 and #003 interacting with each before the incident.

In an interview with resident #002 who was with resident #001 when the incident suddenly occurred, told the inspector that they did not know why resident #001 had suddenly attacked resident #003. Resident #002 abruptly ended the interview with the inspector citing that it was upsetting for them.

In an interview with resident #003, they remembered being attacked by resident #001 and told the inspector they were looking at them when they suddenly attacked them. Resident #003 told the inspector they were afraid of resident

#001 and felt scared and unsafe.

In an interview with the DOC, they acknowledged that physical abuse had occurred as resident #003 sustained injuries during the altercation they had with resident #001.
(649)

2. A CIS report was submitted to the MLTC, related to an identified injury of unknown cause to resident #005's identified body part. On an identified date, an x-ray report indicated that resident #005 sustained an identified injury.

A review of resident #005's progress notes indicated there was a previous CIS report submitted to the MLTC, related to an allegation of visitor to resident physical abuse. According to the CIS report Personal Care Provider (PCP) #137 witnessed resident #005 and an identified family member crossing the street and had observed the resident's family member physically abuse the resident. According to the CIS report, the DOC spoke with the resident who denied the allegation. The DOC spoke with the resident's above identified family member who denied the allegation of physical abuse.

Further review of a progress note dated on an identified date indicated that the resident reported to two registered staff that their above identified family member had physically abused them and that they had done it on and off over the last few weeks, because they were not perfect. The resident was asked if they were physically abused by the identified family member on the same day and they told staff that they were.

According to resident #005's progress notes as a result of the above incident, the home advised another specified family member, who agreed that the resident's identified family member will only visit the resident with another family member present.

According to a progress note dated on an identified date, resident #005's above identified family member had visited them unsupervised at an identified time and remained in an identified home area with the resident during a meal service.

According to a progress note dated on another identified date after the above

mentioned visit indicated that resident #005 was found to have altered skin integrity on their above identified body part.

Another progress note indicated that resident #005 complained of pain to their identified body part to PCP #118, who inquired with the resident if anyone had hurt them; the resident responded yes and named their above identified family member.

Resident #005 was not interviewable during the inspection due to cognitive impairment.

During an interview PCP #118 told the inspector they had asked the resident how they hurt their identified body part, and the resident told them that it was their identified family member.

In an interview with PCP #119 who had been working with the resident since their admission to the home, they told the inspector that they had observed the resident's above identified family member agitated and abrupt with the resident approximately one year ago but had since noticed an improvement. When the PCP was asked if the identified family member massages the resident's above identified body part, they responded that they did, and explained that they had reported to the home as they were quite rough. They further explained that instead of just massaging the resident's identified body part they would squeeze a bit harder on identified body parts and had observed finger prints in these areas.

In interviews with RPN #110, RCC #122, and ADOC #133 they all acknowledged that based on the above, mentioned definition that physical abuse toward resident #005 had occurred since the resident had reported that their identified family member had physically abused them resulting in above identified injury. (649)

3. The licensee has failed to ensure that resident #005 was not neglected by the licensee or staff.

A CIS report was submitted to the MLTC, related to an identified altered skin integrity of unknown cause on resident #005's identified body part. An x-ray

report indicated that resident #005 sustained an identified injury on the above identified body part.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “neglect means” the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Record review indicated upon the initial discovery of the identified altered skin integrity on an identified date the resident had complained of soreness when asked by RPN #110 to perform range of motion (ROM). According to the RPN’s assessment swelling was observed, the resident was administered an identified medication, and another identified treatment was applied. A pain assessment completed indicated pain was minor. The resident was unable to say how they had sustained the identified altered skin integrity. According to a later progress note indicated that resident #005’s identified family member approached RPN #110 and reported that the resident did not seem their usual self. The RPN documented that the resident was noted to be pale and lethargic, vitals signs were checked, and the resident was transferred to bed. No further action was completed at this time.

A review of progress notes dated on the above identified date indicated that RCC #123 had been informed of resident #005’s identified altered skin integrity and they were informed by RPN regarding the redness and soreness on the resident’s identified body part. They documented no swelling was noted, and a message was left for the resident’s identified family member. There was no documentation by the RCC of any action taken when they became aware of the resident’s identified altered skin integrity.

Further review indicated on the above identified date, the resident had remained in bed during the shift. They appeared anxious, was complaining they could not breathe, and had refused oxygen via nasal prongs. Despite these changes no documentation of any action or further assessment was taken regarding the resident’s above identified altered skin integrity, swelling, and soreness with ROM.

According to another progress note, it was documented on the night shift that the resident did not sleep well, and an identified medication was administered. There was no documentation of a reassessment completed.

A review of progress notes indicated that the above identified altered skin integrity on the identified body part of the resident was getting larger and was purplish in color. The resident did not complain of pain. The resident's above identified family member visited them and was upset that their identified altered skin integrity had worsened and requested to have the resident seen by a physician. According to the progress note, the family member was told there was no physician in the home, and they decided to take the resident to hospital to have an x-ray done. The resident returned from hospital the same day with a new treatment for their above identified body part. The family member verbally informed the home that the resident had been diagnosed with an identified injury to the above identified body part.

Record review indicated an identified hospital's diagnostic report, that resident #005 had above identified injury.

Resident #005 was not interviewable during the inspection due to cognitive decline.

In an interview with RPN #110, they told the inspector that in hindsight they should have sent the resident to the hospital.

In an interview with RCC #123, they told the inspector that they had assessed the resident on the identified date and indicated there was no swelling but was unaware of the resident having difficulty with ROM due to soreness. When the inspector further questioned if they had completed an assessment of the resident, they responded that they could not remember. There was no documentation of an assessment completed by RCC #123 of resident #005's identified skin integrity when it was reported to them.

In an interview with RCC #122, they told the inspector in response to what action should have been taken by the home when resident #005 was first identified with the identified altered skin integrity, they indicated that if the resident was having pain with ROM the physician should have been called for an x-ray. RCC

#122 confirmed based on the above definition that neglect had occurred.

Resident #005 was identified with the above identified altered skin integrity of unknown cause on the identified body part, there was documentation of soreness with ROM and swelling, no action or further assessment was taken by the home until the resident's identified family member asked for the resident to be seen by the physician. The family member took the resident to hospital for an x-ray which confirmed the above identified injury, this indicates a pattern of inaction by the home.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 3 history of previous non-compliance with this subsection of the Act that included:

- Voluntary plan of correction (VPC) issued June 27, 2017, (2017_632502_0007)
- Compliance Order (CO) issued August 01, 2017, (2017_526664_0006)

Additionally, the LTCH has a history of three other compliance orders in the last 36 months.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2020

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. 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 complaint with O. Reg. 79/10, s. 36 of the LTCHA 2007.

Specifically, the licensee must:

1.Ensure that all staff use safe transferring and positioning devices or techniques when assisting residents #011, #012, and #013 and all other residents in the home.

2. Ensure that all staff follow the home's transfer equipment manufacturer's guide, and relevant guidance and instructions specified in individual residents care plans, specifically to transfer equipment's size and transferring using mechanical lift to ensure resident safety.

3. Ensure that all staff to use safe and proper assistance and techniques when assisting residents from the floor after a fall and transferring them manually or by using mechanical lift.

4. Develop and implement an on-going auditing process to ensure that all staff are using safe transferring and positioning devices or techniques when assisting residents. Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluation of the results. The written record must also include the date and location of the audit, resident's name, name of staff members audited, name of the person completing the audit, and the outcome and follow-up of the audit results.

Grounds / Motifs :

1. The licensee has failed to ensure that staff had used safe transferring and positioning devices or techniques when assisting resident #011, #012 and #013.

A CIS report was submitted to the MLTC, related to resident #011's fall resulting in an injury.

Review of the CIS report indicated that resident #011 had a fall on an identified date and time, the resident was found on the floor on an identified resident home area. Upon assessment the resident complained of pain in an identified body part, and swelling was noted on their identified body parts. The resident was transferred to the hospital and returned the same day with the diagnosis of an identified injury.

Review of the resident's plan of care indicated that they required identified assistance from staff with transfer and toileting.

Review of resident #011's progress notes on the above identified date, indicated that the resident was found on the floor on the identified resident home area and a PCP then transferred the resident to the bed.

Review of the home's investigation notes of an interview conducted with PCP #107, indicated that the resident was found on the floor on the identified resident home area by the PCP. The PCP then transferred the resident to bed on their own prior to the resident being assessed by a registered staff. The notes further indicated that RPN #103 had gone to another unit, and the PCP could not reach them when they had called after finding the resident on the floor.

Further review of the home's investigation notes and interview with staff educator #104 indicated that PCP #107 was provided with education on the home's Personal Support Worker (PSW) Guidebook under the falls section, after the incident mentioned above. Review of the guidebook, titled: Nursing Procedures, under the fall section indicated as follows:
-In an event of a fall PSWs to report to registered staff immediately, and
- Do not attempt to move the resident until they have been assessed by a registered staff.

Interview with resident #011 indicated that they could recall the above

mentioned fall incident. The resident explained that they fell facing down on the floor on the identified resident home area. PCP #107 had hurt their identified body part while manually lifting them up holding them while standing behind their back. They further explained that the PCP had put both of their arms underneath their shoulders and manually lifted them up from the floor. They told the PCP to stop as it was causing them pain, and they did not stop.

Interview with RPN #103 indicated that PCP #107 had notified them of the resident's fall after they fell on the identified date. The resident was already transferred to bed when the RPN went to assess them after the fall. The RPN further explained that as per the home's expectations after each fall, residents should be assessed by a registered staff prior to moving them, and at least two staff should assist the resident to prevent any further injuries. The RPN further stated that this was not done for resident #011.

Interview with PCP #107 indicated that they found the resident on the floor on the identified date. They called RPN #103 on their pager and could not reach them. They went ahead and manually lifted the resident to bed without assistance from another staff, prior to being assessed by the registered staff. PCP acknowledged the resident should have been assisted by two PCPs and was required to be assessed by a registered staff after the fall and prior to the transfer to bed.

Interview with the DOC indicated that after the fall, the resident should have been assessed by a registered staff prior to being transferred by a PCP, and two staff should have assisted the resident with the transfer from floor to bed. PCP #107 did not use safe transferring techniques when they had transferred resident #011 from the floor after the fall.
(654)

2. Resident #012 and #013 were used to expand the resident sample size due to non-compliance found for resident #011.

(A) During an observation on an identified date, inspector observed resident #012 being transferred from bed to their wheelchair by PCPs #116 and #146. An identified transfer device with an identified size of transfer equipment was used by the PCPs to transfer the resident. A transfer logo was observed in the

resident's room indicating to use a different size of transfer equipment for mechanical transfer.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) identified that resident #012 required specific assistance with specific number of staff members, using the identified transfer device.

Record review of resident #012's transfer and lift assessment and plan of care indicated the resident should be transferred using the above identified transfer device with a specified size of transfer equipment, with specific number of staff members.

Separate interviews with PCP #116 and #118 indicated they used an identified different size of transfer equipment during resident #012's mechanical transfer. They confirmed that the resident was required to be transferred using the above specified size of equipment as indicated on their transfer logo. PCP #116 indicated they could not find the above specified size of transfer equipment in the resident's room and had used the one they could find.

(B) During another observation on the identified date resident #013 was observed being transferred from bed to their wheelchair by PCP #148 and RPN #147. An identified transfer device with an identified size of transfer equipment was used by the PCP and RPN to transfer the resident. A transfer logo was observed in the resident's room indicating to use a different size of transfer equipment for mechanical transfer.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) identified that resident #013 required specific assistance with specific number of staff members, using the identified transfer device.

Record review of the resident #013's transfer and lift assessment and plan of care indicated, the resident should be transferred using the identified transfer device with a specified size of transfer equipment, with specific number of staff members.

In separate interviews with PCP #148 and RPN #147 they indicated that a different size of transfer equipment was used during resident #013's mechanical

transfer. They confirmed that the resident was required to be transferred using the above specified size of equipment as indicated on their transfer logo. PCP #148 indicated that the different size of transfer equipment was already in the resident's room and they did not verify the equipment size with their transfer logo prior to using it.

Interview with RPN #147 indicated that PCPs and registered staff both were responsible to ensure that the right size of transfer equipment was used prior to transferring any resident when using the identified transfer device. Using the wrong size of transfer equipment could put residents at potential risk for injury.

A review of the home's policy titled, Mechanical Lifts and Resident Transfers (LTC-CA-WQ-200-0712), last revised July 2019, identified that the identified transfer equipment required to be visibly inspected prior to use.

Review of the identified transfer equipment sizing manufacturer's guide used by the home titled Tollos product guide, identified a specific size of transfer equipment to be used for weight between 75-124 Pounds (lbs)/ 34- 56.2 Kilograms (kgs). A warning on the guide indicated that failure to use the appropriate size and type can result in serious injury.

During interview with RCC #122, they reviewed the transfer equipment sizing guide and indicated that for residents' weight between 34- 56.2 Kilograms (kgs) the above specified size of transfer equipment should be used for mechanical transfers. The RN reviewed both residents' weights and indicated that resident #012 and #013's current weights were between the above mentioned weight range. By using the different size of transfer equipment staff did not follow the home's sling sizing guide.

Interview with the ADOC #133 indicated that staff were responsible to check the residents transfer equipment size to ensure that it matched with their transfer logo posted in residents' rooms and plan of care. Staff did not use safe transferring devices when transferring resident #012 and #013 from bed to wheelchair.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to three

of three residents reviewed. The home had a level 3 history of previous non-compliance with this subsection of the Act that included:

• Voluntary plan of correction (VPC) issued January 25, 2017, (2016_413500_0012)
• Compliance Order (CO) issued June 27, 2017, (2017_632502_0007)
Additionally, the LTCH has a history of three other compliance orders in the last 36 months.

(654)

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

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 16th day of October, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Simar Kaur

Service Area Office / Bureau régional de services : Central East Service Area Office