Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 24, 2024	
Inspection Number: 2024-1373-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Woodhaven, Markham	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6 - 9, 12 - 15, 2024.

The following intake(s) were inspected:

· One intake related to an outbreak.
· Two complaint intakes related to falls prevention and management.
· Two intakes related to improper/incompetent treatment.
· One intake related to staff to resident neglect.
· Two intakes related to resident-to-resident physical abuse.
· One complaint intake related to responsive behaviours.

· One intake related to fall with injury. · One intake related to injury not caused by a fall.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home is a safe and secure environment for its residents.

Rationale and Summary

During an inspection of the Long-Term Care Home (LTCH) it was observed that in different Resident Home Areas (RHAs) identified as Family Rooms, there were posted signs indicating not to leave personal belongings in the room, and to store

personal belongings in the designated lockers.
In different occasions and home units, the following was observed:
On a specific date, in the family room, on an identified home area:
- staff personal belongings such as bags, lunch bags, and food items.
- a green bottle labelled "Primary Liquid Acrylic".
- two bottles of body lotion.
- staff taking their breaks with residents present.
At the time of the observation the home unit was under an outbreak.
On a different date, in the family room, on a different home area:
-staff back packs.
On another date, in the family room, in another home area:
-personal belongings including a purse and water bottle.
-a student taking their break with a resident present in the room.

The Director of Care (DOC) indicated that outbreak unit staff and rest of the staff have designated break areas to store their personal belongings. in a designated area.

Failure to ensure that resident areas that were secured and maintained in a safe state, placed the residents of the home at risk of harm.

Sources: Observations, LTCH's posted signage in the family rooms, and interview with the DOC.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written

plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that resident #012's care plan set clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
Resident #012's written care plan indicated that staff members were to use a specific device for all transfers.

In the resident's room, a posted sign indicated the required assistance for transfers.

Personal Support Worker (PSW) #120, Registered Practical Nurse (RPN)# 110, and Registered Nurse (RN) #113 indicated that resident # 012 required specific assistance for all transfers. Furthermore, RN #113 acknowledged the sign posted on the resident's room could confuse staff for transfers, and it was not a clear direction to follow.

Failing to ensure that the care plan provided clear direction to staff regarding transfers, placed resident #012 at risk of injuries during transfer.

Sources: Plan of care for resident #012, interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee failed to ensure that resident #013 was not neglected by staff.

Section 2 of O. Reg. 246/22 s. 7 defines neglect as "the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes in action or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary
A Critical Incident Report (CIR) for an incident of neglect was submitted to the Director, indicating that resident #013 had been left unattended by PSW#122, for an extensive period.

The home's investigation notes documented that PSW #122 had left resident #013 unattended. Subsequently, a PSW from the following shift found the resident.

Resident #013 confirmed being left unattended by PSW #122 for a long period of time, and no physical harm was reported.

The DOC confirmed the home's investigation concluded that PSW #122 had neglected resident #013. In addition, the DOC confirmed the staff was no longer working at the home.

Failing to protect resident #013 from neglect, placed the resident at a higher risk of harm.

Sources: CIR, home's investigation notes, interviews with resident #013, and DOC.

WRITTEN NOTIFICATION: Protection from certain restraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 34 (1) 3.

Protection from certain restraining

s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

3. Restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39.

The licensee failed to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39.

Rationale and Summary

A complaint was reported to the Ministry of Long Term Care (MLTC) related to resident #006's falls prevention and management.

The resident's health records identified them at high risk for falls.

PSW #107 was observed applying a device against the resident's bedside. In total, two devices were placed against the resident's bed.

The home's restraints policy indicated that if a device affects the person's ability to get up from the bed or chair, it was considered a restraint.

RPN #112 and PSW #107 confirmed staff used the devices against the resident's bedside. Additionally, the staff confirmed this practice was not part of the resident's plan of care, and it was a practice to prevent resident from falling.

Resident Care Coordinator (RCC) #113 and DOC confirmed the use of the device against the resident's bed was considered a physical restraint.

Failure to ensure that resident #006 was not restrained using a physical device, placed the resident at risk of harm.

Sources: Observations, LTCH's restraints policy, , interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee failed to ensure the equipment and devices identified in the care plan for resident #005 related to the falls prevention and management were in place and in working condition.

Rationale and Summary
A complaint was reported to the MLTC related to resident #005's falls prevention and management.

Resident #005's clinical records indicated that as part of the fall interventions, a safety device was to be applied.

Inspector #741722 observed a device on top of a chair near the window on the resident's room.

PSW #107 indicated the device located on top of the chair, was for the resident but it was not in working condition, and it had not been reported to be fixed.

RCC #113, indicated the assigned PSW to the resident 's care was to report to the registered staff on the floor if the device was not in working condition, so it could be repaired or replaced.

Failure to ensure resident #005's equipment and devices for the prevention of falls were in place and functioning appropriately, might increase the risk for falls and prevent staff to promptly respond to the resident's care needs.

Sources: Resident #005's clinical records, observation, interviews with PSW #107 and RCC #113.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that resident #011, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

The clinical record of resident #011 indicated that areas of altered skin integrity were identified on the resident. An initial assessment was done on a specific date. Their clinical records indicated that weekly reassessments were not completed.

RPN #121 confirmed that they did an initial skin assessment and had to reassess at least weekly, but they did not complete it, and was unaware if a reassessment had been done.

The DOC acknowledged that the weekly skin reassessments of resident #011 should have been completed.

Failing to reassess resident #011's skin integrity weekly, might have a delayed interventions for the resident.

Sources: Resident #011's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)

Responsive behaviours

s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,

(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to coordinate and implement on an interdisciplinary basis for resident #003's responsive behaviours.

Rationale and Summary

The home submitted a Critical Incident System Report (CIS) regarding resident to resident physical abuse, and a complaint was also submitted to the Director regarding the same issue.

As per residents #003's care plan, they exhibited behaviours towards co-residents and staff.

Multiple incidents occurred due to resident #003's responsive behaviours between specific months. Documented incidents happened in an identified home area and were intervened by registered staff.

Resident #003's electronic documents indicated that the home had completed the Dementia Observational System (DOS) after each incident, with no changes in the resident's plan of care after each DOS.

The Behavioural Supports Ontario (BSO) Lead indicated there had been numerous incidents between resident #003 and other residents and staff due to their responsive behaviours. The BSO Lead also mentioned the home was supported by the Mackenzie Health Behavioural Support Services Mobile Team, but there was no consultation for resident #003.

The DOC confirmed that the last time the home made a referral to a specialist was the done several months ago, and no referral to specialized sources was made for the resident after the incident.

Failing to coordinate and implement an interdisciplinary treatment for resident #003 responsive behaviours, led to an increased risk of reoccurring incidents of physical and verbal harm towards other residents and staff.

Sources: Resident #003's health records, interviews with BSO Lead and DOC.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that interventions were developed and implemented to assist residents and staff who were at risk of harm from resident's #003 behaviours to minimize the risk of altercations and potentially harmful interactions between and among residents

Rationale and Summary

The home submitted a CIS regarding a resident to resident physical abuse, and a complaint was submitted to the Director regarding the same issue.

As per resident #003's plan of care, they exhibited behaviours towards co-residents as they were triggered by identified factors. Staff removed the co-resident away from resident #003 to reduce triggers.

Multiple incidents were documented between specific dates due to resident #003's responsive behaviours. The incidents happened on an identified home area, and

registered staff intervened by removing other co-residents from the area.
RPN #110 indicated there had been numerous incidents between resident #003 and co-residents and staff due to resident responsive behavior that made co-residents scared.

Resident #008, confirmed that resident #003 exhibited specific behaviours towards PSWs. Additionally, resident #008 indicated feeling unsafe when resident #003 was around.

The DOC acknowledged that the resident's responsive behaviour was triggered by identified factors and mentioned that for the other residents' safety, the home advised the resident to be moved to another floor, and have private dining, which the family refused and there was no other intervention were in place regarding this concern.

Ineffective implementation of behavioural management for resident #003, led to an increased risk of reoccurring incidents of physical and verbal harm towards other residents and staff.

Sources: Plan of care for residents #002 and #003, interviews with RPN #110, DOC and resident #008.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).
The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee failed to ensure that additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal; were followed as is it required by Additional Precautions 9.1 (f) under the IPAC Standard for Long Term Care Homes, dated September 2023.

Rationale and Summary
Posted signage at the entrance door of resident #006's room indicated additional precautions were in place.

Health records related to resident #006 identified them as positive for an infectious disease.

Personal Support Worker (PSW) #107 was observed inside the room, assisting with the feeding of resident #006. The staff was observed wearing a surgical mask, gloves, and gown, in close proximity from the resident. After assisting the resident, staff was observed doffing the gloves, gown and completing hand hygiene. The staff was observed exiting the room with the same surgical mask that was used to assist the resident.

The PSW indicated that proper selection of the required PPE and appropriate donning was not followed, as a respirator was required and eye protection. In addition, they confirmed they should have changed the surgical mask when exiting the resident's room.

Failure to ensure that PPE requirements including appropriate selection application,

removal and disposal were followed by the staff, could lead to transmission of infection.

Sources: Observations, progress notes of resident #006, interview with PSW #107.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead had education and experience in IPAC practices.

Rationale and Summary
During an inspection, information related to the new IPAC lead of the home was reviewed.

The DOC indicated the IPAC lead was hired on a specific day, and had started on their current role as an IPAC lead on some days after.

Documentation related to the education and training records for the IPAC lead indicated the staff had initiated the onboarding/orientation checklist for the IPAC lead on weeks after, and pending topics were to be reviewed on a specific date with the Director of Infection Prevention and Control.

The IPAC lead indicated they worked as a registered practical nurse (RPN) in Long Term Care and Retirement Homes, but they had no previous IPAC experience, and no education required for an IPAC lead.

Failure to designate the IPAC lead role to a staff member with education and experience in infection prevention and control increases the risk of poor management of the IPAC program.

Sources: Training and onboarding records for IPAC lead, and interviews with the DOC, and IPAC lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary
During an inspection information related to the new IPAC lead of the home was reviewed.

Records provided by the DOC, indicated that the Clinical Coordinator #111 was covering as the home's IPAC lead for a specific period.

The DOC indicated the previous IPAC lead worked on their role until an identified date, and the recently hired IPAC lead started on their role days after. Additionally, the manager confirmed the Clinical Coordinator was covering as the IPAC lead during this period.

The clinical coordinator #111 indicated during the identified period, they were overseeing the nursing department including the IPAC role, as the Director of Care was on vacation at that time. In addition, staff confirmed there was no tracking of

hours related to IPAC duties and role during this time.

By failing to have a designated staff for the IPAC program of the home, there was a potential risk to the effective implementation of infection control practices, and wellbeing to the residents of the LTCH.

Sources: Email from the DOC, interviews with the DOC and staff #111.

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure that when the Substitute Decision Maker (SDM) of resident #007 expressed their matter of concern related to resident #007's fall, a documented record was kept in the home.

Rationale and Summary
A complaint was lodged to the Ministry of Long-Term Care (MLTC) related to

resident #007's falls management.

Resident #007's health records indicated that on a specific date, they sustained a fall, requiring hospital transfer shortly after. The resident was readmitted to the Long-Term Care Home (LTCH) days after.

On an identified date, a care conference was held in which the resident's SDM expressed their concerns around how the fall took place. As per the note, the management team indicated they were going to complete a thorough investigation. The CIR submitted to the Director, related to the fall, indicated that on a specific date, the SDM was contacted with the outcome of the investigation.

Review of the home's complaint binder did not contain records related to the matter of concern and actions taken by the home related to the internal investigation.

RCC #113 indicated the SDM had expressed feeling upset about the resident's fall and wanted to know further details of how it happened. The RCC and Associate Director of Care (ADOC) indicated they were going to follow up and provide an update, but they didn't follow up with the SDM.

The DOC indicated information related to the fall was documented as part of the CI and confirmed that there were no records related to the complaint. Additionally, the manager indicated the follow up with the SDM was completed days after.

Failing to ensure that records of the complaint related to resident #007 were documented and kept in the home, may have impacted how issues were addressed.

Sources: Resident #007's health records, LTCH's Complaints Binder 2024, CIR, , interviews with RCC #113 and DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that reports made to the Director included the names of any staff members who were present at or discovered the incident.

Rationale and Summary
The home submitted a CIR related to resident to resident abuse. The CIR did not include the name of the staff member who discovered the incident.

The DOC confirmed that the home missed to include the staff name who discovered the incident in the report.

Sources: CIR, and interview with the DOC.

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 3 (1) 11.

Residents' Bill of Rights

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 live in a safe and clean environment.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall, at a minimum:

1. DOC to coordinate and implement an interdisciplinary meeting, including the BSO lead, physician, Director of Care, and external sources, for resident #003's responsive behaviours every two weeks for three months.

a) Keep documented records of the meeting date, participants, and contents of the review. Make the records available upon the inspector's request.

2. The BSO Lead, and a delegate of the nursing management team shall complete a review of resident #003's responsive behaviours to assist in making revisions to resident #003's plan of care to minimize the risk of altercations between co-residents of the home.

3. The nursing management team or BSO Lead is to develop and implement a resident safety plan when resident #003 is present in a resident common area.

Grounds

The licensee has failed to ensure that resident #002 has the right to live in a safe

environment.

Rationale and Summary
The home submitted CIR related to an alleged abuse of resident #002 by resident #003. A complaint was also submitted to the Director regarding the same issue.

As per the resident #003's plan of care, they exhibited specific behaviours. There were multiple incidents due to resident #003 responsive behaviours documented between a specific period. Documented incidents happened in an identified home area, towards staff and co-residents.

Interviews with RPN # 110 indicated numerous incidents were happening between resident #003 and residents and staff due to the resident's responsive behaviour.

Interviews with residents #008 and #002, confirmed that resident #003 had exhibited specific responsive behaviours. They expressed feeling unsafe when resident #003 was around.

Failing to ensure that a safe environment was kept in the home, placed resident #002 and other residents at risk of harm.

Sources: Plan of care for resident #002 and #003; Interview with RPN #110, DOC and resident #008.

This order must be complied with by November 25, 2024

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:

1. Educate all PSWs, including agency PSWs in the two specific resident home areas, on the home's policies and procedures related to the use of safe transferring and positioning devices or techniques , at a minimum, education of mechanical lifts, transfer to mobility device.

a) The education will be conducted by the nursing management team or physiotherapist.

b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

Grounds
1). The licensee failed to ensure staff used safe transferring techniques for resident #001.

Rationale and Summary
The home submitted a CIR regarding improper and incompetent care for resident #001.

Resident #001's clinical records indicated that during a transfer, resident #001 fell to the floor sustaining an injury.

Resident's care plan indicated they required a specific assistance for transfers. PSW #109 had not followed the direction, resulting in resident #001's fall with an injury.

The home's internal investigation concluded that improper care/treatment occurred, and PSW #122 provided care without the specific assistance for transfers.

Interviews with DOC confirmed that the unsafe transfer happened.

Failing to use safe transferring techniques led to resident's #001 fall and injury.

Sources: CIR and interview with the DOC.

2). The licensee failed to ensure staff used safe transferring techniques when using a device for resident #012.

Rationale and Summary
The home submitted a CIR regrading a fracture not related to a fall of resident #012.

The clinical record indicated resident #012 was being assisted when an identified body part was injured in the metal component of their device. The site was assessed by RPN #110 and was noted to be painful. The resident was sent to the hospital for further evaluation, where it was determined that they sustained a fracture.

The home's internal investigation indicated that when staff were assisting resident #012 a body part was injured in the metal component of their device.

Interviews with RPN #110 and DOC confirmed that the unsafe transfer happened.
The staff was suspended from work and re-educated on the home-safe transferring policy.
Failing to use safe transferring techniques led to resident's #012 injury.

Sources: CIR and interviews with the RPN #110 and DOC.

This order must be complied with by November 25, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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