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

Toronto District
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Original Public Report

Report Issue Date: June 13, 2024
Inspection Number: 2024-1427-0002
Inspection Type: Proactive Compliance Inspection
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 Westbury, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2024.06.21 10:13:34 -04'00'

Additional Inspector(s)
Chinonye Nwankpa (000715)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26, 29, 30, 2024 and May 1-3, 6 -9, 2024

The following intake(s) were inspected:

- Intake: #00114548 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure that they sought the advice of the Residents' Council, in carrying out the Resident and Family/Caregiver Experience Survey and in acting on its results.

Rationale and Summary

Review of the Family Council Meeting Minutes and interview with a Family Council

member identified that the licensee did not seek the advice of the Family Council in carrying out the Resident and Family/Caregiver Experience Survey or in acting on it results in 2023.

The Administrator acknowledged that the licensee had not sought the advice of the Family Council in acting on the results of the 2023 Resident and Family/Caregiver Experience Survey.

Sources: Review of 2023 Family Council Meeting Minutes; interview with a Family Council member, Administrator, and other staff.

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WRITTEN NOTIFICATION: TRAINING

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The licensee has failed to ensure that staff received training in the areas of infection prevention and control (IPAC) prior to performing their responsibilities.

Rationale and Summary:
The inspector randomly selected and reviewed Infection Prevention and Control (IPAC) training records for newly hired staff. Housekeeping staff #114 did not complete training on IPAC topics at the time of orientation. The Housekeeping staff reported that they completed the training five months after hire.

The Administrator reported that all new hired staff participated in orientation training which includes IPAC prior to the start of their job duties and acknowledged that the Housekeeping staff had not completed IPAC training as required.

Failure of the home to ensure that newly hired staff completed IPAC training increased the risk of new staff not following the home's IPAC practices.

Sources: Review of Housekeeping staff #114 training records, interviews with Housekeeping staff # 114, Administrator and other staff.

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WRITTEN NOTIFICATION: TRAINING

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee failed to ensure that staff received training in the areas of skin and wound, pain, continence care, restraints, falls prevention and mechanical lift prior to performing their responsibilities.

Rationale and Summary
The home's Orientation policy states that newly hired staff will complete mandatory orientation training prior to completing any job task. The orientation training was completed via the home's onboarding materials and by the electronic educational platform Surge Learning.

Director of Care (DOC) #101 stated that the newly hired staff will receive on site general training with the Educator, then complete comprehensive training through Surge Learning.

Review of the following staff orientation training records identified that they did not receive training in the following areas prior to performing their responsibilities.

a) Personal Support Worker #116 was hired on an identified date. Surge Learning records identified they completed the mandatory orientation training which includes fall prevention, skin and wound, pain, continence care, restraints and mechanical lifts three months after hire.

b) Personal Support Worker #135 was hired on an identified date. Surge Learning records identified they completed the mandatory orientation training which included, fall preventions, pain, continence, skin and wound, restraints and mechanical lift three months after hire

c) Personal Support Worker #136 was hired on an identified date. Surge Learning

records identified the mandatory orientation training which included, fall preventions, skin and wound, pain, restraints and mechanical lift was not completed at the time of this inspection.

d) Personal Support Worker #137 was hired on an identified date. Surge Learning records identified they completed the mandatory orientation training which included, fall preventions, pain, continence three months after hire; and skin and wound, restraints and mechanical lift not completed at the time of this inspection.

DOC #101 confirmed that the four identified Personal Support Worker (PSW) staff did not complete the mandatory orientation training prior to starting their job duties.

Sources: Review of PSW #116, PSW #135, PSW #136 and PSW #137 training records, interview with PSW #116, DOC #101 and other staff.

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WRITTEN NOTIFICATION: DOORS IN A HOME

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, or doors that residents do not have access to must be kept closed and locked.

Rationale and Summary
Observations on April 26, 30, May 1, and 2, 2024, revealed that the exit door leading to the underground parking area were unlocked, hence no access code was required to enter or exit through the doors. Residents and others entering the main elevators could exit the building using these exit doors through the parking lot, especially without any locks or security measures in place.

Environmental Service Manager (ESM) #105 confirmed the exit door leading to the underground parking area started displaying mechanical issues some weeks ago. The Administrator and ESM #105 both noted that an access code known to staff and visitors only was supposed to be used to open the doors, otherwise the doors were supposed to stay locked at all times.

Failing to ensure the exit door was secure posed a safety risk to residents.

Sources: Observations on April 26, 30, May 1, and 2, 2024; Interviews with ESM #105 and the Administrator.

[000715]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by resident #017 at all times.

Rationale and Summary
Resident #017 was observed lying in bed however, their call bell was not within their reach. The call bell cord was seen dangling over the head of the bed with the push button on the floor. Resident #017's care plan stated their call bell was to be clipped to their pillow or placed within their reach.

PSW #126 acknowledged they failed to put the call bell within the resident's reach while they were in bed.

There was an increased risk of harm to the resident when the call bell was not within their reach.

Sources: Observations of resident; Resident #017's care plan; Interview with PSW #126.

[000715]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

The licensee has failed to ensure that continence care products were not used as an alternative to providing assistance to toileting resident #022.

Rationale and Summary
An observation revealed that at a specific time, resident #022 was wearing two incontinent products. The inner product was full of urine. Resident #022's care plan noted they required continence care products, and referred to a continence product list which specified they should be provided an incontinent product during the day.

The home's Job Routine for PSWs policy noted that resident should be provided continence assistance every three hours.

Resident #022 shared that they normally received continence care twice during the morning shift, first before breakfast where the staff applied two incontinent products and secondly in the afternoon when one of the products would be removed while they were in the chair. The resident reported feeling uncomfortable and experiencing pain as a result of wearing two incontinent products.

PSW #129 acknowledged that they applied two incontinent products on the resident at the start of their shift and did not provide continence care for six hours. PSW #129 confirmed that applying the two incontinent products allowed staff to avoid providing continence care, which required the resident to be transferred from their wheelchair back to bed to be changed. PSW #129 noted that for about a year, they applied two incontinent products at the start of their shift, then would pull out the inner incontinent product while resident was seated in the chair.

Registered Nurse (RN) #131 acknowledged that resident #022 was wearing two incontinent products, and that this was not documented in their care plan. Administrator #100 and DOC #101 both confirmed that PSW #129 should have applied only one incontinent product, and that applying more than one product simultaneously was against the home's policy.

There was increased risk of continence related issues to resident #022 when staff failed to provide continence care product changes.

Sources: Resident's clinical records, Job Routine for PSWs policy, no date; interviews with resident #022, PSW #129, RN #131, Administrator #100, DOC #101 and other staff.

[000715]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

The licensee has failed to ensure that residents who required continence care products have sufficient changes to remain clean, dry and comfortable, specifically resident #022.

Rationale and Summary
On an identified date, resident #022 did not receive continence care for approximately six hours during the day shift. An observation revealed that the resident was wearing two incontinent products, one of which was full of urine. The resident's care plan noted they required continence care products.

The home's Job Routine for PSWs policy noted that resident should be provided continence assistance every three hours.

Resident #022 shared that they normally received continence care twice during the morning shift, first before breakfast and secondly in the afternoon. The resident reported feeling uncomfortable when they did not receive continence care for approximately six hours.

PSW #129 acknowledged that on the specific date, they only provided continence care to the resident once during their shift . Administrator #100 and DOC #101 both confirmed that resident #022 did not receive continence care at the frequency specified in the home's policy.

There was increased risk of continence related issues to resident #022 when staff

failed to provide more frequent continence care.

Sources: Resident's clinical records, Job Routine for PSWs policy, no date; interviews with resident #022, PSW #129, RN #131, Administrator #100, DOC #101 and other staff.

[000715]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The home has failed to ensure that as part of the organized program of housekeeping, the licensee's procedures were followed for cleaning and disinfection of shared equipment using at a minimum a low-level disinfectant (LLD).

Rationale and Summary
The home used Accelerated Intervention low-level disinfectant (LLD) wipes for the purpose of cleaning and disinfecting resident shared equipment, such as shower

chairs.

On an identified date, PSW #118 entered the shower room to assist resident #011 with their shower. After the shower, PSW #118 reported that they used the Accelerated Intervention LLD wipes to clean the shower chair before and after use. The inspector observed the LLD wipes had an expiration date of March 9, 2024 (03/09/2024).

DOC #103 stated that they were unclear regarding the expiry date (Month/Day/Year vs Day/Month/Year). The inspector confirmed with the manufacturer that the expiry date was Month/Day/Year.

The IPAC Lead stated that expired LLDs were no longer considered a LLD as it had lost it's effectiveness when frequently touched contact surfaces were cleaned and disinfected.

The use of expired LLD to clean and disinfect shared equipment placed the residents and staff at risk of infection transmission since it reduced the effectiveness of the LLD used in the home's housekeeping program.

Sources: Observations on an identified date/unit shower room, review of Accelerated Intervention One Step Surface Cleaner and Disinfectant label and expiration date; and interviews with DOC # 103, IPAC Lead and other staff.

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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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
RPN #121 was observed doing a medication pass for multiple residents, but did not perform hand hygiene before and after resident contact when administering their medications.

RPN #121 acknowledged that they failed to perform hand hygiene between administration of medicines to residents. DOC #101 noted that nurses were expected to perform hand hygiene before and after administering medications to residents during a medication pass.

Failing to follow proper hand hygiene practices increased the risk of infection transmission.

Sources: Observations on an identified date; Interviews with RPN #121 and DOC #101.

[000715]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee has failed to ensure that drugs were stored in an area, that was used exclusively for drugs and drug-related supplies.

Rationale and Summary
On a specific date, an observation revealed medications were being stored in the medication fridges along with non-medication items on multiple home areas including applesauce bottles, small food packages, and bottled liquids. The home's Medication Administration Policy stated that the medication fridge was to be used to store only medications.

DOC #101 confirmed the fridges in the home had both medication and non-

medication items stored in them.

There was an increased risk when the home failed to properly store the medications.

Sources: Observations on an identified date; Medication Administration Policy LTC-CA-WQ-200-06-01, last revised December 2017; Interviews with DOC #101.

[000715]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area, specifically in the medication fridge.

Rationale and Summary
An observation revealed medications were being stored in the medication fridge inside the medication room on fifth floor, including injectable narcotic medications for resident #008. The medication fridge had only one external lock, and no other lock was observed in the fridge's interior.

DOC #101 confirmed the fridges in the home did not have a double-lock system, hence the narcotic medications were stored in the single-lock fridge.

There was an increased risk of unsafely storing controlled substances when the home failed to properly secure the medications.

Sources: Observations on an identified date; Interviews with DOC #101.

[000715]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure the Quality Initiative Report was provided to the Family Council.

Rationale and Summary
The Family Council 2022 and 2023 meeting minutes were reviewed.

The Administrator and a Family Council member confirmed that the home's 2022-

2023 Continuous Quality Improvement (CQI) Initiative Report was not shared with the Family Council at the home.

Sources: Review of Family Council Meeting Minutes, interview with the Administrator #100 and a Family Council member.

[189]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING-DIRECT CARE STAFF

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that the falls prevention and management training was provided to all staff who provided direct care to residents.

Rationale and Summary
The home's training records revealed that five PSWs hired in 2023 had not received training on falls prevention and management. In addition, three PSWs and one RPN hired in 2024 did not receive the above training.

DOC #103 acknowledged that mandatory orientation training for the falls prevention and management program was not completed by the staff noted above as per the home's policy.

There was increased risk of provision of safe care when staff did not complete their annual training.

Sources: Surge learning 2023 to 2024 report; interview with DOC #103.

[000715]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING- DIRECT CARE STAFF

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all staff who provided direct care to residents receive annual training provided for in subsection 82 (7) of the Act, specifically falls prevention and management and pain management.

Rationale and Summary

1. The home's surge learning report for 2023 showed that three PSWs did not complete the annual training for the pain management program.

DOC #103 acknowledged that annual mandatory training for the pain management program was not completed by all staff in 2023.

There was increased risk not providing safe and competent care when staff did not complete their annual training.

Sources: Surge learning 2023 report; interview with DOC #103.

[000715]

2. The home's surge learning report for 2023 showed that three PSWs did not complete the annual training for the falls prevention and management program.

DOC #103 acknowledged that annual mandatory training for the falls prevention and management program was not completed by all staff in 2023 as per the home's policy.

There was increased risk of not providing safe and competent care when staff did not complete their annual training.

Sources: Surge learning 2023 report; interview with DOC #103.

[000715]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 6 (7) [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that steps are taken to ensure the care set out in the plan of care of residents #001 and #020 was provided as specified in their plans.

The plan shall include but is not limited to:

- Process to ensure that resident #001 is being provided the food and fluids consistency as specified in their care plan.
- Process to ensure that pre-thickened fluids are identified by the type of thickness used in policies and care plans.
- Education provided to all nursing staff an identified unit including but not limited to PSWs, Nurses, Nursing students, Agency staff, on fluid consistencies and pre-thickened fluids.
- Process to ensure that resident #020 is being repositioned at the frequency specified in their care plan.

- Process to ensure that the care plan level of assistance required to reposition and provide continence care to resident #020 is provided as specified in their plan.
- Process to ensure the toileting and/or continence care frequency and level of assistance is identified and implemented for residents.
- Education provided to all nursing staff on an identified unit including but not limited to PSWs, Nurses, Nursing students, Agency staff, on providing the appropriate level of assistance to residents during repositioning and continence care as specified in care plans.
- The plan should include identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component mentioned above within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2024-1427-0002 to Nicole Ranger (189), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by June 27, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001 and #020 as specified in their plans.

Rationale and Summary

1. RPN #121 was observed giving pre-thickened fluids to resident #001 during a medication pass. The packaging of the fluids administered stated mildly thickened consistency. Resident #001's care plan noted they were to be fed honey thickened fluids.

Food and Nutrition Manager (FNM) #123 stated that mildly thickened consistency of the pre-thickened fluids administered to the resident was equivalent to nectar thickness. RPN #121 noted that they fed the resident the wrong fluid consistency, as the resident was given nectar fluid consistency instead of honey consistency.

Failing to give resident #001 the appropriate fluid consistency as per their care plan increased their risk of choking or aspiration.

Sources: Observations on a specific date; Interviews with RPN #121 and FNM #123.

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2. On an identified date, resident #020 was not repositioned at the frequency specified in their care plan. The resident's care plan noted that the resident was bedridden and required two-staff assistance with repositioning every two hours. During an observation conducted on a specific date, between 1135 hours and 1452 hours, resident #020 was not repositioned by staff. However, the PSW documentation survey report showed that PSW #138 had documented they performed the repositioning at 0830 hours, 1030 hours, 1230 hours and 1430 hours.

Resident #020 reported that staff have not been providing repositioning assistance every two hours, and that they were positioned lying on their back all the time. PSW #138 confirmed that they were not repositioning the resident every two hours. PSW #138 acknowledged they repositioned the resident only twice during their eight-hour shift at approximately 0715 hours and 1115 hours on an identified date.

There was increased risk of skin injury to the resident when the staff failed to provide repositioning assistance as specified in their care plan.

Sources: Observation on an identified date; resident #020's care plan, PSW Documentations Survey Report; interviews with resident #020 and PSW #138.

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3. Resident #020's care plan stated they required two staff for repositioning and continence care assistance. However, on an identified date, PSW #138 performed the repositioning without another staff present.

Video surveillance revealed that on an identified date, aside from PSW #138 who entered resident #020's room, no other staff entered or exited the room.

Resident #020 shared that on an identified date, only one staff performed their continence care. PSW #138 acknowledged that they performed the repositioning and continence care to resident #020 without the assistance of a second staff.

There was increased risk of injury to the resident when the staff failed to provide the required amount of assistance for continence and repositioning as specified in their care plan.

Sources: Resident #020's care plan, video surveillance record; interviews with resident #020 and PSW #138.

[000715]

This order must be complied with by August 7, 2024

COMPLIANCE ORDER CO #002 TRANSFERRING AND POSITIONING TECHNIQUES

NC #016 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 prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 40 [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that steps are taken to ensure that staff use safe transferring techniques when assisting residents.

The plan shall include but is not limited to:

- Process to ensure that residents on an identified unit are being transferred safely by staff with the appropriate techniques, devices and level of assistance as specified in their plan.
- Conduct random audits to ensure compliance with transfer requirements.
- Education provided to PSWs #129 and #130 on the importance of using the appropriate level of assistance specified in residents' care plans.
- Education provided to PSWs #129 and #130 on the home's Lifts and Transfer policy and procedures, as well as the transferring and lifting devices used by the home.
- The plan should include identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component mentioned above within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2024-1427-0002 to Nicole Ranger (189), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by June 27, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that staff used safe transferring techniques when they assisted residents.

Rationale and Summary

The home's Mechanical Lifts and Resident Transfers policy specified that two staff were required at all times when a mechanical lift was being used to transfer and/or lift a resident. A video surveillance record showed that on an identified date, unsafe transfers were perform for residents #019, #021, #022, #023, and #024 by PSWs #129 and #130. The below transfers occurred on an identified date:

1. Resident #019's care plan noted they required two staff with a mechanical lift for transfers. However the video record showed that PSW #130 took a lifting device into the resident's room on their own and came out with the device and the resident in a wheelchair.
2. Resident #021's care plan noted they required two staff assistance for transfers. However the video record showed that PSW #129 went into the resident's room on their own and came out with the resident in a wheelchair.
3. Resident #022's care plan noted they required two staff with a mechanical lift for transfers. However the video record showed that PSW #129 took a lifting device into the resident's room on their own and came out with the device. The resident was seen afterwards in a wheelchair.
4. Resident #023's care plan noted they required two staff with a mechanical lift for transfers. However the video record showed that PSW #130 took a lifting

device into the resident's room on their own and came out with the device. The resident was seen afterwards in a wheelchair.

5. Resident #024's care plan noted they required two staff with a mechanical lift for transfers. However the video record showed that PSW #129 took a lifting device into the resident's room on their own and came out with the device. The resident was seen afterwards in a wheelchair.

PSWs #129 and #130 both acknowledged they performed unsafe resident transfers on an identified date. Administrator #100 and DOC #101 both confirmed that residents #019, #021, #022, #023, and #024 were unsafely transferred by PSWs #129 and #130 because they performed the transfer without assistance of a second staff as per the home' policy.

There was increased risk of injury to the residents when the staff failed to use safe transferring techniques.

Sources: Residents clinical records, Video surveillance record, Mechanical Lifts and Resident Transfers policy, LTC-CA-WQ-200-01-01, Last revised July 2023; interviews with PSW #129, PSW #130, Administrator #100, DOC #101 and other staff.

[000715]

This order must be complied with by

August 7, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE 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.