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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 8, 2023

Inspection Number: 2023-1448-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: The Women's Christian Association of London

Long Term Care Home and City: McCormick Home, London

Lead Inspector	**Inspector Digital Signature**
Cassandra Aleksic (689)	Cassandra N Aleksic Digitally signed by Cassandra N Aleksic Date: 2023.02.14 15:36:52 -05'00'

Additional Inspector(s)
Samantha Perry (740)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 18, 19, 20, 23, 25 and 26, 2023

The following intake(s) were inspected:

- Intake: #00018005, CI #2965-000004-23 related to falls with injury.
- Intake: #00002999 - Complaint concerns related to resident care and transferring and positioning.
- Intake: #00005798, CI #2965-000030-22 related to transferring and positioning techniques.
- Intake: #00016244, CI #2965-000048-22/2965-000002-23 related to resident neglect and care concerns.
- Intake: #00016347, CI #2965-000046-22 related to resident neglect and care concerns.

The following intake(s) were completed in this inspection:

- Intake: #00001519, CI #2965-000016-22; Intake: #00011125, CI #2965-000037-22; Intake: #00012304, CI #2965-000041-22 related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 stated under section 10.1: "The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR."

Public Health Ontario Fact Sheet Titled, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated "do not use expired product. Be sure to note product expiration date when selecting product."

During an initial tour of the home on January 18, 2023, Inspector #689 identified ABHR and sanitizing wipes made available in resident rooms and common areas that were expired or did not have expiry dates.

The Director of Care (DOC) was informed and all expired products from the resident rooms and common areas were removed and replaced.

The risk to the residents was low, as the home had non-expired product available throughout the home areas.

Sources: Observations of resident room and home areas; and interview with the Director of Care (interim IPAC lead).

Date Remedy Implemented: January 25, 2023 [689]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 40

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

Specifically, the licensee must:

a) Ensure staff use safe lift and transferring techniques as per the home's policies and procedures when assisting resident #001 and resident #004, in accordance with their plan of care.
b) Ensure that all personal support care staff receive in-person education by an Arjo representative or staff member who has completed the Arjo key operator training on two specific types of equipment. A record will be maintained in the home, including the re-education information/details, the name of the staff, staff designation, date of education and signatures of completion.
c) Upon completion of part B) of the order, management (or delegate) will complete an in-person/visual audit of both a mechanical lift and sit to stand lift transfer to ensure residents are being transferred per education and manufacturer's instructions. The audit will be completed at least once a week in various home areas on both pieces of equipment. A record will be maintained including the management or delegate completing the audit, the name of staff member(s) performing the lift/transfer, the type of equipment used, name of resident, date of

transfer and actions taken to correct any deficiencies. The weekly audit will continue until the compliance order has been complied by an inspector.

Grounds
Non-compliance with: O. Reg. 246/22, s. 40

A) The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #001.

Rationale and Summary
The Ministry of Long Term Care (MLTC) received a complaint related to resident care concerns including, safe transferring and positioning techniques.

A review of resident #001's clinical records documented all transfers were to be completed with the assistance of two staff members and using a specific piece of lift equipment.
The McCormick Care Group, Manual: Musculoskeletal Program Policy Manual, Subject: Mechanical Lifts, last reviewed: May 2022, documented the McCormick Care Group is equipped with various types of mechanical lifts. The fourth statement documented under the heading, "Procedure" states, "Nursing staff MUST NEVER leave a resident/client unattended in a mechanical lift."

The concerns shared with the MLTC on a specific date, detailed that the resident was brought to a specific room/area with a mechanical lift and positioned. The staff assisting resident #001, then left the specific room/area for specific amount of time, leaving the resident unattended in a mechanical lift.

In an interview with the home's management team, they confirmed, according to their policy and the legislation, no resident was to be left unattended in a mechanical lift.

The risk of an accidental fall or altered skin integrity was increased for resident #001, when they were left unattended in a mechanical lift.

Sources: Resident clinical records, the home's Mechanical Lifts policy and interviews with staff and management. [740]

B) The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #004, resulting in a fall from mechanical lift.

Rationale and Summary
On a specific date, two Personal Support Workers (PSWs) were transferring resident #004 from their assistive device via mechanical lift. During the transfer, the equipment became unhooked from the lift, causing the resident to fall. Resident #004 sustained an injury.

The home's Client Incident Reporting Forms were reviewed which showed statements from the PSWs involved. The reports identified that the staff members used a mechanical lift to transfer resident. The resident's equipment was applied and upon lifting the resident up, the staff heard a "snapping" noise, and the equipment became loose, which caused the resident to fall.

The mechanical lift manufacturer's instructions showed the steps involved when lifting a patient, including the steps for install of the equipment parts.

The Assistant Director of Care (ADOC) and Director of Care (DOC) stated that staff were trained on the use of equipment in accordance with manufacturer's instructions provided by Arjo, who was the homes supplier for lift equipment. They stated that after the incident, the mechanical lift used to transfer resident #004 was inspected on, and there were no mechanical defects identified. The DOC provided the inspector with email records, which documented conversation between the home and Arjo. The home had requested assistance with auditing, an in-service and retraining on equipment parts and lift use. The ADOC and DOC stated that the equipment parts may not have been attached by the staff members. Training records show that the PSWs involved received re-education on the McCormick Care Group resident/client lift, transfer, and positioning policies and procedures, as well as in-service training on the use of lift equipment.

Failing to ensure that staff used safe transferring techniques when assisting resident #004 resulted in a fall with risk of injury.

Sources: Review of Resident #004's plan of care; the Critical Incident System Report and Client Incident Reporting Forms; interviews with the ADOC and DOC, and the equipment's manufacturer's instructions for use. [689]

This order must be complied with by March 31, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.