Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 15, 2018	2018_630589_0001	000878-18	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

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

JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 12, 15, 16, 18, 19, 22, 23, 25, and 26, 2018.

The following critical incident report log #000597-18 related to air temperatures and a follow-up log #002844-17 related to compliance order #001 in resident quality inspection (RQI) report 2017_377502_0017.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Director of Programs and Admissions (DPOA), Director of Environmental Services (DES), Resident Relations Coordinator (RCC), Housekeepers (HSK), Maintenance, Food Services Supervisor (FSS), Director of Dietary Services (DDS), Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS-C), Residents, Substitute Decision Makers (SDMs), President of Residents' Council and co-chairs of Family Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of medication administration system, staff and resident interactions and the provision of care, record review of resident health records, staff training records, air temperatures logs, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
3 VPC(s)
1 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	Legendé 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 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 used safe transferring and positioning devices or techniques when assisting resident.

As a result of compliance order #001 under O. Reg. 79/10, r. 36, served in report #2016_377502_0017, observations of three residents were conducted while being bathed using the Alenti bath chair.

The licensee failed to comply with compliance order #001 from inspection 2016_377502_0017 served on January 25, 2017, with a compliance date of March 31, 2017. The licensee was ordered to:
1. Education for all direct care staff, including:
- the different types of transfer methods and positioning devices that can be used with residents,
- the manner in which identified transfer methods are to be used to ensure resident safety,
2. A system to randomly audit resident transfer practices to ensure:
- staff are transferring and positioning residents as per the residents' individual plan of care.

The home successfully completed item # 2 as ordered; but failed to entirely complete item #1 - the manner in which identified transfer methods are to be used to ensure resident safety at the time the inspectors re-entered the home to inspect this order on January 12, 2018, as demonstrated by the evidence included in this report.

Review of the home's policy titled: Resident Transfer and Lift Procedures, policy number VII-G-20.20 revised May 2017, revealed that PSWs will ensure a second person is in attendance during the transfer using an identified bathing apparatus to guide a resident's legs into and out of the tub and noting the identified bathing apparatus will not be used as a mobility device to be wheeled from the resident's room down the hall to the tub room.

Observations conducted by the inspector revealed staff #121 using the identified bathing apparatus unassisted with resident #018 into and out of the bath tub.

Review of the home's education training records related to the above mentioned compliance order revealed that staff #121 had received education on identified transferring apparatus which included the identified bathing apparatus on two identified dates in January 2017. Further review revealed staff #121 had completed a return demonstration check-off form related to the identified bathing apparatus indicating they had successfully completed the procedures for using this apparatus, had demonstrated the tasks, understood the guidelines that must be followed and it is to be used in compliance with the policy and procedures.

Review of resident #018's written plan of care in place at the time of this inspection revealed they were at risk for injury related to impaired mobility and required assistance with personal care. A further review revealed a cognitive impairment that indicated memory deficits and that decision making skills were noted as modified independence with some difficulty in new situations only.

During an interview, staff #121 stated they were aware the bathing apparatus was a mechanical lift and that two staff are to be present when being used. Staff #121 further stated they thought since resident #018 could ambulate with the use of a mobility aid that it was okay to use the identified bathing apparatus unassisted.

During an interview, resident #018 could not recall if they had received assistance with personal care that morning and could not recall if there was usually only one staff member present when the identified bathing apparatus had been used previously due to the above mentioned cognitive deficits. [s. 36.]

2. Observations conducted by the inspector revealed staff #120 using the identified bathing apparatus unassisted with resident #017 into and out of the bath tub.

Review of the home's education training records related to the above mentioned compliance order revealed that staff #120 had received education on identified transferring apparatus including on the identified bathing apparatus on an identified date in March 2017. Further review revealed that staff #120 had completed a return demonstration check-off form related to the identified bathing apparatus indicating they had successfully completed the procedures for use, had demonstrated the tasks, understood that the guidelines must be followed and it is to be used in compliance with

the policy and procedures.

Review of resident #017's written plan of care in place at the time of this inspection revealed that resident #017 had alteration cognition related to an underlying health condition.The review also revealed that resident #017 required assistance with aspects of their personal care. Further review revealed a moderate cognitive impairment with memory deficits and that decision making skills were noted as moderately impaired with decisions poor, cues or supervision required.

During an interview, staff #120 stated they were not aware that the identified bathing apparatus was considered a mechanical lift. Staff #120 further stated they had not received any updates that this identified bathing apparatus was a mechanical lift.

During an interview, resident #017 recalled that they had received personal care that morning but could not recall if there usually was only one staff member present when the identified bathing apparatus had been used previously due to the above mentioned cognitive deficits.

During interviews, staff #112, staff #126 and staff #100 stated the identified bathing apparatus was to be considered a mechanical lift and therefore two staff are to be present when being used with a resident.

During an interview, staff #100 stated that it was disappointing that after all the education provided to staff that they were not using the identified bathing apparatus properly. Staff #100 acknowledged that staff #120 and #121 had failed to use safe transferring and positioning techniques when providing personal care to resident #017 and #018 respectively, using the identified bathing apparatus.

The scope of this non-compliance is isolated to resident's #017 and #018, The severity is minimal harm/risk to potential for harm/risk as resident #018 was at risk for injury. The previous compliance history revealed a previous non-compliance under O. Reg. 79/10, was issued as a compliance order in RQI report #2016_377502_0017 on January 25, 2016, with a compliance date of March 31, 2017. Due to ongoing non-compliance with O. Reg. 79/10, r. 36., a compliance order is warranted to be re-issued. [s. 36.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

Resident #005 triggered in stage one of the resident quality inspection (RQI) for further inspection.

Review of resident #005's health record revealed they had been admitted to the long term care home (LTCH) with multiple underlying health conditions. Review of the admission assessment revealed an identified weight and height with a body mass index (BMI) within normal range. Resident #005 was deemed at moderate nutritional risk by the registered dietitian (RD) as was meeting their daily nutritional requirements at that time.

Review of resident #005's health record from August 2017, to January 2018, revealed a gradual weight loss. During the month of October 2017, resident #005's weight was obtained on two occasions indicating a fluctuation of 3.7 kilograms (kg) between the two

weights. On an identified date in November 2017, staff #123 completed an assessment which indicated that resident #005's current BMI was now below normal range.

During an interview, staff #123 stated that a referral to the RD for resident #005 should have been completed for the gradual weight variance and change in their BMI. Staff #123 further stated resident #005 had experienced a weight variance over an identified period and that they had documented that these should have been referred to the RD.

During an interview, staff #111 stated they had not received a referral for resident #005's weight variance or change in BMI.

During an interview, staff #123 acknowledged they had indicated in the assessment a referral to the RD was required but had neglected to follow through with the referral. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #002 was triggered during stage one of the RQI for further inspection.

During an interview, staff #203 stated that resident #002 had food preferences and that the home had updated resident #002’s plan of care to reflect this. They further stated that resident #002 should receive identified portions of their food preferences at identified meal services; however their observations revealed that resident #002 was not receiving their food preferences as per the plan of care.

Record review revealed that resident #002 required assistance with their dietary intake. Review of the dietary list indicated resident #002's food preferences.

Observations by the inspector during a lunch service revealed staff #134 assisting resident #002 with their meal. Staff #114 who was also present in the dining room and asked staff #134 if resident #002 had received their food preference to which staff #134 responded no. Staff #114 then approached the servery and spoke to a staff member about resident #002's food preferences; however, they were still not provided their food preference as identified in the plan of care.

During an interview on the same day, staff #134 was able to recall what resident #002 had consumed during their meal. Staff #134 further stated that it was their first time

working on this resident home area (RHA), and that they had not reviewed resident #002's plan of care; therefore, was not aware of resident #002's food and fluid preferences.

Further observations by the inspector during another lunch service revealed that resident #002's food preferences had been placed at their place setting. Two inspectors observed staff #116 assist resident #002 with one of their food preferences and that the second food preference was not offered.

During an interview, staff #116 stated that they were aware that resident #002 was to receive an identified number of portions related to their food preference at this meal service. Staff #116 further stated that resident #002 only consumed one serving of their food preference, refusing the second. When informed that the offer of the second food serving was not observed by the inspector, staff #116 stated they had offered one of the food servings that had been sitting on the table. When asked if the resident refused because the food serving was cold, PSW stated that they did not know.

During an interview, staff #114 stated that staff #134 should have checked the plan of care including the diet list before assisting resident #002. They further stated that staff #116 should have offered a second food serving. Staff #114 confirmed that resident #002 had not received two servings of their food preferences on two identified dates in January 2018, and as such, the care set out in the plan of care was not provided to resident #002. [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure the temperatures in the home were maintained at a minimum of 22 degrees Celsius.

The Ministry of Health and Long Term Care (MOHLTC) received critical incident report (CIR) related to temperatures in the home. The CIR revealed that on an identified date in January 2018, due to the severity of the cold weather outside, temperatures in the home had dropped to below 22 degrees Celsius in resident rooms. Two residents required to be relocated within the home on the above mentioned date due to their room temperature recorded at below 14 degrees Celsius, all other residents did not require relocation.

Review of the home's daily air temperature logs from November 2017 to the current time of inspection revealed that only hallway temperatures were being documented routinely and that they were being documented in Fahrenheit. Further in-depth review of the daily air temperature logs converted to Celsius from December 25 to 31, 2017, revealed hallway temperatures ranged from 15.5 to 21.6 Celsius and from January 1 to 19, 2018, revealed hallway temperatures ranged from 16.1 to 25.5 Celsius.
Review of resident's room temperatures taken on an identified date in January 2018, revealed the following air temperatures:
-on Wing One room temperatures ranged from 14 to 22 degrees Celsius,
-on Wing Two room temperatures ranged from 15.5 to 19.5 degrees Celsius,
-on Wing Three room temperatures ranged from 11.8 to 17.7 degrees Celsius and,
-on Wing Four room temperatures ranged from 15.1 to 21 degrees Celsius.
Further review of room temperatures on two identified dates in January 2018, revealed resident room temperatures ranged from 16.3 to 23.9 degrees Celsius. Air temperatures were noted to be maintained at 22 degrees Celsius in all resident rooms starting on an identified date in January 2018, three days after the initial phone notification to the MOH had been made.

A review of service order from the home's heating and air conditioning (HVAC) contractor

for the above mentioned dates in January 2018, revealed the operation of duct heaters were verified as operational and working at full capacity and the electrical contractor service order revealed that dedicated liners were added to identified rooms to install plugs for heaters.

During interviews, resident's #011 and #014 complained of the home being cold during the above mentioned dates in January. Resident #014 further stated that there had been a portable heater in their room since November 2017, and that their room is still cold, especially the bathroom. Observations conducted by the inspector on an identified date in January 2018, revealed that upon entering the bathroom of resident #014's room it felt cool noting a heating lamp in the ceiling. Resident #014 also stated that staff #112 had come into their room on an identified date in January 2018, to take the room temperature a few times. During an interview, staff #110 acknowledged that the home had been cold on the above mentioned weekend.

During an interview, staff #106 stated that resident's bathrooms do not have heat sources, only cold air duct returns, resident room windows are single pane and that the walls in the home are not insulated.

On an identified date in January 2018, the inspector and staff #106 toured the home and measured air temperatures with a portable infrared thermometer in common areas of the home and in randomly selected resident rooms. Air temperatures in random resident rooms were noted to be maintained at 22 degrees Celsius however the air temperature in a common area located in the centre of the home, had air temperatures that fluctuated between 19.8 to 24 degrees Celsius depending on where the portable infrared thermometer was pointed at with a median air temperature of 21.4 degrees Celsius.

During an interview, staff #100 stated that they had requested for the corporate Environmental Consultant (CEC) to conduct an assessment of the home however no date had been confirmed as of the time of this inspection. Staff #100 acknowledged that the home had not maintained air temperatures at 22 degrees Celsius as per legislative requirements. [s. 21.]

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 the temperature in the home maintained at a minimum of 22 degrees Celsius, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incidents involving a resident and every adverse drug reactions were reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The medication inspection protocol was completed as one of the mandatory tasks of the RQI.

Record review of the home's medication incident records revealed there had been two incidents involving two residents on two separate identified dates in November 2017, where the residents' family had not been notified nor had an investigation been completed for either of these incidents, respectively.

During interviews, staff #144 and staff #141 stated that in the above two incidents, the residents' family members should have been notified.

During an interview, staff #126 confirmed that the above two incidents should be reported to the residents' family, and this had not been done. [s. 135. (1)]

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b).

Record review of the home's medication incident records revealed four incidents had occurred, two on identified dates in October 2017, and two on identified dates in November 2017. Further review indicated the two incidents from October 2017, had been investigated by the home's pharmacy provider and not the home and that the two incidents from November 2017, had not been investigated by either the pharmacy provider or the home. Review of the above mentioned residents' health records involved in the incidents did not indicate that any harm was caused by these incidents.

During an interview, staff #110, staff #144, staff #141 stated that the home's process for addressing medication incident includes the completion of an online report which is sent to the pharmacy to investigate. Staff #110 stated that the staff #112 also investigates, but that they were not clear about the process of how the staff #112 is informed of the incident. Staff #144 and staff #141 stated that the online report is automatically sent to staff #100 and staff #126 upon submission.

During an interview, staff #112 stated that the responsibility to investigate medication incidents is that of the DOC.

During an interview, staff #133 stated that the initial medication incidents submitted on the online pharmacy website are sent to the pharmacy manager, staff #133, and staff #100. When the pharmacy manager completes their investigation, it is then sent to the DOC of the home, and staff #133. Staff #133 stated that the emails were being sent to the email of previous DOC of the home instead of the current DOC.

During an interview, staff #100 stated that that they had not been receiving any emails related to medication incidents.

During an interview, staff #126 stated that they had not been informed of any medication incidents since they began their position of DOC in October 2017, as such, they had not reviewed, analyzed or taken necessary corrective actions related to any of above mentioned incidents. Staff #126 stated that the above mentioned incidents presented minimal or potential harm to the involved residents. [s. 135. (2)]

3. The licensee has failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

Record review of the home's medication incident records revealed a quarterly review of all medication incidents and adverse drug reactions had not been completed.

During an interview, staff #126 stated they had not been informed of any medication incidents since beginning their position of DOC in October 2017, therefore, they had not reviewed, analyzed or taken necessary corrective actions related to any of above mentioned incidents. Staff #126 confirmed that quarterly reviews of all medication incidents and adverse drug reactions had not been completed prior to their start date, or since then. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, all medication incidents and adverse drug reactions are reviewed and analyzed, that corrective action is taken as necessary, and that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home, to be implemented voluntarily.

Issued on this 22nd day of February, 2018

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

Ministére 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673)
Inspection No. / No de l'inspection :	2018_630589_0001
Log No. / No de registre :	000878-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 15, 2018
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Smith

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére 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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_377502_0017, CO #001;

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 compliant with s.36., specifically,
1.Review the proper operation of the Alenti bath chair with PSWs #120 and #121 and invite other PSWs that may be uncertain of the proper use of the bath chair to attend the review. Names of attendees and content of review to be available to inspectors on request.
2.The licensee will ensure that all direct care staff use safe transferring and positioning devices or techniques when assisting any residents that require transferring with a mechanical lifting device, and
3.Develop an auditing tool enabling the documentation of random audits of staff, ensuring they are using safe transferring and positioning devices or techniques when assisting any residents that require a mechanical lifting device for transfers and bathing.

Grounds / Motifs :

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

As a result of compliance order #001 under O. Reg. 79/10, r. 36, served in report #2016_377502_0017, observations of three residents were conducted while being bathed using the Alenti bath chair.

The licensee failed to comply with compliance order #001 from inspection 2016_377502_0017 served on January 25, 2017, with a compliance date of March 31, 2017. The licensee was ordered to:
1. Education for all direct care staff, including:

- the different types of transfer methods and positioning devices that can be used with residents,
- the manner in which identified transfer methods are to be used to ensure resident safety,
2. A system to randomly audit resident transfer practices to ensure:
- staff are transferring and positioning residents as per the residents' individual plan of care.

The home successfully completed item # 2 as ordered; but failed to entirely complete item #1 - the manner in which identified transfer methods are to be used to ensure resident safety at the time the inspectors re-entered the home to inspect this order on January 12, 2018, as demonstrated by the evidence included in this report.

Review of the home's policy titled: Resident Transfer and Lift Procedures, policy number VII-G-20.20 revised May 2017, revealed that PSWs will ensure a second person is in attendance during the transfer using an identified bathing apparatus to guide a resident's legs into and out of the tub and noting the identified bathing apparatus will not be used as a mobility device to be wheeled from the resident's room down the hall to the tub room.

Observations conducted by the inspector revealed staff #121 using the identified bathing apparatus unassisted with resident #018 into and out of the bath tub.

Review of the home's education training records related to the above mentioned compliance order revealed that staff #121 had received education on identified transferring apparatus which included the identified bathing apparatus on two identified dates in January 2017. Further review revealed staff #121 had completed a return demonstration check-off form related to the identified bathing apparatus indicating they had successfully completed the procedures for using this apparatus, had demonstrated the tasks, understood the guidelines that must be followed and it is to be used in compliance with the policy and procedures.

Review of resident #018's written plan of care in place at the time of this inspection revealed they were at risk for injury related to impaired mobility and required assistance with personal care. A further review revealed a cognitive impairment that indicated memory deficits and that decision making skills were noted as modified independence with some difficulty in new situations only.

During an interview, staff #121 stated they were aware the bathing apparatus was a mechanical lift and that two staff are to be present when being used. Staff #121 further stated they thought since resident #018 could ambulate with the use of a mobility aid that it was okay to use the identified bathing apparatus unassisted.

During an interview, resident #018 could not recall if they had received assistance with personal care that morning and could not recall if there was usually only one staff member present when the identified bathing apparatus had been used previously due to the above mentioned cognitive deficits. [s. 36.]

2. Observations conducted by the inspector revealed staff #120 using the identified bathing apparatus unassisted with resident #017 into and out of the bath tub.

Review of the home's education training records related to the above mentioned compliance order revealed that staff #120 had received education on identified transferring apparatus including on the identified bathing apparatus on an identified date in March 2017. Further review revealed that staff #120 had completed a return demonstration check-off form related to the identified bathing apparatus indicating they had successfully completed the procedures for use, had demonstrated the tasks, understood that the guidelines must be followed and it is to be used in compliance with the policy and procedures.

Review of resident #017's written plan of care in place at the time of this inspection revealed that resident #017 had alteration cognition related to an underlying health condition.The review also revealed that resident #017 required assistance with aspects of their personal care. Further review revealed a moderate cognitive impairment with memory deficits and that decision making skills were noted as moderately impaired with decisions poor, cues or supervision required.

During an interview, staff #120 stated they were not aware that the identified bathing apparatus was considered a mechanical lift. Staff #120 further stated they had not received any updates that this identified bathing apparatus was a mechanical lift.

During an interview, resident #017 recalled that they had received personal care that morning but could not recall if there usually was only one staff member

present when the identified bathing apparatus had been used previously due to the above mentioned cognitive deficits.

During interviews, staff #112, staff #126 and staff #100 stated the identified bathing apparatus was to be considered a mechanical lift and therefore two staff are to be present when being used with a resident.

During an interview, staff #100 stated that it was disappointing that after all the education provided to staff that they were not using the identified bathing apparatus properly. Staff #100 acknowledged that staff #120 and #121 had failed to use safe transferring and positioning techniques when providing personal care to resident #017 and #018 respectively, using the identified bathing apparatus. (589)

2. On January 25, 2018, observations conducted by the inspector revealed PSW #120 using the Alenti bath chair to transfer resident #017 into and out of the bath tub unassisted.

Review of the home's education training records related to the above mentioned compliance order revealed that PSW #120 had received education on the Alenti bath chair, Sara 3000, Maxi Move, Tempo, ceiling lift, pivot and zero lift on March 24, 2017. Further review revealed that on March 24, 2017, PSW #120 had completed a return demonstration check-off on the Alenti which indicated they had successfully completed the procedures for using the Alenti and had demonstrated the tasks and understood that the Alenti guidelines must be followed and it is to be used to comply with the policy and procedures.

Review of resident #017's written plan of care in place at the time of this inspection revealed under the Cognitive Loss Dementia focus that resident #017 had alteration in thought processes related to unspecified dementia evidenced by having difficulty in completing sentences sometimes and/or tasks and under the activities of daily living (ADL) focus, resident #017 required extensive assistance with bathing. A review of resident #017's most recent resident assessment instrument-minimum data set (RAI-MDS) revealed a cognitive performance scale (CPS) score of three indicating moderate cognitive impairment, under section B-cognitive patterns; resident #017 had short term memory deficits and that decision making skills was noted as moderately impaired with decisions poor, cues or supervision required.

During an interview, PSW #120 stated they were not aware that the Alenti bath chair was considered a mechanical lift. PSW #120 further stated they had not received any updates that the Alenti bath chair is a mechanical lift.

During an interview, resident #017 recalled that they had received a bath that morning but could not recall if there usually was only one staff member present in the tub room during the use of the Alenti bath chair due to the above mentioned cognitive deficits.

During interviews, ADOC #112, DOC #126 and ED #100 stated the Alenti bath chair is to be considered a mechanical lift and therefore two staff are to be present when being used to bath a resident.

During an interview, ED #100 stated that it was disappointing that after all the education provided to staff that they were not using the Alenti bath chair properly. ED #100 acknowledged that PSWs #120 and #121 had failed to use safe transferring and positioning techniques when bathing resident #017 and #018 respectively, using the Alenti bath chair.

The scope of this non-compliance is isolated to resident's #017 and #018, The severity is minimal harm/risk to potential for harm/risk as resident #018 is at risk for falls. The previous compliance history revealed a previous non-compliance under O. Reg. 79/10, was issued as a compliance order in RQI report #2016_377502_0017 on January 25, 2016, with a compliance date of March 31, 2017. Due to ongoing non-compliance with O. Reg. 79/10, r. 36., a compliance order is warranted to be re-issued. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	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 15th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : Joanne Zahur

Service Area Office / Bureau régional de services : Toronto Service Area Office