Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_751649_0005 (A2)	000722-19, 001094-19	Complaint

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

Amended by JOY IERACI (665) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date for CO #001 and CO #002 was changed to September 30, 2019.

Issued on this 16th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

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Amended by JOY IERACI (665) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 22, 26, 28, March 1, 4, 5, 6, 7, 8, 11, 18, 19, 28, April 4, and 8 (off-site), 2019.

The following intakes were inspected:

Log#001094-19 related to transferring and positioning technique and Critical Incident System (CIS) #2824-000002-19/ log #000722-19 related to staff to resident abuse.

A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 36 was identified in Complaint Inspection #2019_751649_0007 (Complaint Inspection Logs #017637-17, #021191-17, #024831-17, #027623-17, #002255-18, #004566-18, #005264-18, #011942-18, #028106-18, #028521-18, #032377-18, #032514-18, and #004329-19) which was conducted concurrently with this inspection, and issued in this report.

A Compliance Order (CO) related to O. Reg. 79/10 s. 36 and a Voluntary Plan of Correction (VPC) related to LTCHA, 2007, s. 19(1) were identified in Critical Incident System (CIS) Inspection #2019_751649_0008 (CIS Logs #025996-17, #023840-18, #030782-18, #031734-18, #033041-18, and #003022-19) dated May 14, 2019, which were conducted concurrently with this inspection, and issued in this report.

During the course of the inspection, the inspector(s) spoke with Director of Resident Care and Experience (DRCE), manager long term care (MLTC), manager security telecommunication & emergency prepardness (MSTEP), administrative secretary, physician, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and family members.

During the course of the inspection the inspector observed staff to resident interactions, conducted observations of the resident and interviews, reviewed resident health records, investigation notes, audio and video surveillance, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents #060 and #001 were not neglected by the licensee or staff.

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

(a) A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #060 reported to a family member during their visit that they fell.

According to the complainant, the family member immediately inquired with the nursing staff who denied that the resident fell and reported they were unwell and had been in bed for the last few days. The resident also reported to the complainant and the family member that there were a lot of people who helped them and specifically identified PSW #201. The resident told the complainant and their family member that they had hit an identified body area, the family member examined the area but did not observe an injury.

The inspector tried to interview the resident but they were not interviewable. Voice recordings were obtained and reviewed of the resident saying that they fell and had pain to an identified area.

According to the complainant, on an identified date the resident was visited by a friend (#198) who they told that an identified area hurt and they fell. Once again the resident identified PSW #201 as the person who helped them. In an interview with the resident's friend they reported that the resident was in an identified location when they visited them and was told by staff that the resident had pain to an identified area. The resident's friend #198 tried to help the resident to sit up but they started to scream don't touch me it is painful.

The complainant told the inspector that on an identified date, resident #060's family member was contacted by the resident's physician and they asked why the resident was not in their usual location. They expressed concern about this to the physician and that the resident had reported that they fell. According to the complainant, the physician did not have any report of the resident falling but was going to look into it. The family member was once again contacted by the resident's physician on the same day, who told them they were sending the resident to the hospital as it appeared that the resident may have had an identified medical condition. The resident was transferred to hospital for further assessment.

The complainant told the inspector that the resident was assessed in hospital and reported that the resident had sustained multiple injuries to an identified area.

A review of the hospital consultation report indicated that the resident had an injury to an identified area. The hospital consultation report further stated that this injury was likely the result of an un-witnessed fall.

A review of the resident's #060 progress notes did not indicate any documentation that the resident had suffered a recent fall or any other related injury. The complainant expressed suspicion to the inspector that an accident may had occurred on an identified date as the family member was told by the home when they visited that the resident had been in an identified area for the last couple of days.

On an identified date, according to the 24-hour nursing hand-written report and point click care (PCC) progress notes, resident #060 was put in an identified location because they were not feeling well and was moaning and complaining of undescribed pain. Scheduled pain medication was given. There was no documentation of the site of the resident's pain. Progress notes and staff interviews indicated that resident frequently complain of pain to an identified area.

According to the 24-hour nursing hand-written report documented on the day shift on an identified date indicated an injury was indicated on an identified area by RPN #194 while they were taking the resident's vitals.

In an interview with RPN #194, they told the inspector the home's process related to the injury was to report it to the physician, family, manager, and complete a

skin assessment in PCC. According to the RPN they had not reported the injury to the physician, nor to the resident's family, and had not completed a skin assessment in PCC. The RPN told the inspector that they thought that the resident had just bumped the identified area was not suspicious of any other cause.

In an interview with RN #202 who worked when the injury was initially identified, they told the inspector that they had assessed the injury. According to RN they had not documented their assessment and told the inspector that they delegated this task to RPN #194. The inspector asked if they had followed up the following day when they worked they responded that they knew the RPN would always put a note in the doctor's book and had not asked them because they thought the RPN knew.

According to the 24-hour nursing hand-written report the resident remained in an identified location for several days.

In an interview with the resident's physician #200 they had been informed by the home's staff on an identified date that the resident had been in an identified location for the last several days. The physician told the inspector that the resident likes to be in their mobility device in an identified location. According to the physician when they first examined the resident they were not immediately concerned. The physician told the inspector that when the resident was later assessed up in their mobility device they were suspicious of an identified medical condition. The physician further explained that the resident presentation at the time of the assessment was unusual for this resident and ordered the resident transferred to hospital for further assessment.

The inspector reviewed the home's video surveillance. According to the video surveillance on an identified date resident #060 was transferred by PSW #201 using the mechanical lift by themselves; the resident's care plan and the home's transfer policy states that it should be done with two staff.
A second PSW was never seen entering the resident's room on an identified date to assist with the resident's mechanical lift transfer.

In an interview with PSW #201, who was seen in the home's video surveillance on an identified date, bringing the resident out of their room told the inspector they were not assigned to resident #060 on that day, it was PSW #131's assignment. According to PSW #201 while they were walking past resident #060's room they

saw that the resident wanted to get up as their feet were hanging off the bed, from below the knee. The inspector asked if they provided any assistance when they observed the resident's feet off the bed and they responded that they had not. The PSW further explained that they had gone into the resident's room and spoken with the resident asking them to wait for five minutes and the resident nodded their head. According to the PSW they did not provide any assistance to the resident at this time as they knew it was the resident's shower day. The PSW told the inspector that they had provided care and transferred resident #060 with PSW #196 on an identified date. The inspector showed PSW #201 the home's video surveillance on the identified date which showed that PSW #196 was never seen entering resident #060's room to assist them with the transfer. PSW #201 denied transferring resident #060 by themselves on an identified date and denied that the resident had sustained any fall or injury.

In a letter obtained from the home addressed to PSW #201 stated that according to the home's video surveillance a second staff was never seen assisting with the resident's transfer on an identified date. According to the letter the home concluded that PSW #201 had transferred resident #060 by themselves on an identified date, and a significant trauma had occurred during the resident transfer which they had failed to report, resulting in the resident not receiving any treatment for several days for an injury. PSW #201 received disciplinary action.

In an interview with PSW #196, they initially told the inspector that the resident was in an identified location when PSW #201 had asked for their help on an identified date. According to PSW #196 when they first saw the resident they were in an identified location just about to be transferred. A review of the staffing schedule for this period indicated that the alleged date of the incident, had been the first day that PSWs #201 and #196 were assigned. The inspector asked what assistance did the resident require with the transfer and PSW #196 explained that the resident would hold onto the rail, while they applied the sling. According to PSW #196 they were asked by PSW #201 to bring the mechanical lift, which was in the resident's washroom. PSW #196 denied having any knowledge of resident #060 slipping or falling on the identified date.

In a follow up interview with PSW #196 on a later date the inspector showed them the home's video surveillance for the date of the alleged incident. They responded that they do remember helping PSW #201 but could not recall if it was on that day as they had not seen themself in the video surveillance leaving the resident's room. The inspector read PSW #196's response from their previous interview and

they acknowledged that their statement to the inspector was different from what they saw in the video surveillance. When the inspector asked if they had assisted with the resident transfer on the date of the alleged incident, they responded that they did not see themself coming out of the resident's room. The home's video surveillance clearly showed that PSW #196 was never in the resident's room, the staffing schedule showed the alleged date of the incident was the first time that these two staff had worked together, and the documentation indicate when the resident was put back to bed on an identified date and never got up again until when they were transferred to hospital.

The inspector was unable to determine what events had occurred that led to resident #060 being diagnosed at the hospital with an injury.
In an interview with MLTC #149, who was part of the home's investigation, they told the inspector that no fall had been identified during the home's investigation and staff interviews. The manager told the inspector that the staff did not follow the home's transfer policy of two staff for transfer when the mechanical lift was used on identified dates. In response to the question if resident #060 had been neglected if PSW #201 had failed to report that the resident had sustained an injury on the date of the alleged incident, the manager acknowledged that neglect had occurred.

The DRCE was informed about the allegation of neglect related to resident #060.

PSW #201 actions of failing to report that the resident had sustained an injury on an identified date, resulted in the resident not receiving any treatment for several days clearly indicate that the resident had been neglected.

(b) A Critical Incident System (CIS) report was submitted to the MOHLTC related to falls with injury.

A review of the CIS report indicated on an identified date resident #001 was found lying outside their room. The resident had an injury to an identified area and was transferred to the hospital for further assessment and returned to the home at a later date.

Record review and staff interview identified that the resident was known to get out of bed and walk unassisted and had an unsteady gait.

Review of the Resident's Safety Event Reporting System (SERS) and the

progress notes indicated that on an identified date the resident returned to the home from hospital confused and disoriented. The paramedics informed the staff that the resident was sedated and transferred to an identified location. A post fall strategy to prevent recurrence was not identified.

The resident sustained a second fall shortly after they returned from hospital. This fall resulted in worsening of the previous injury. The resident had difficulty walking and was in pain whenever they moved. A post fall strategy to prevent recurrence, included monitoring the resident closely by providing one-on-one (1:1).

On the same day, RN #147 was assigned to provide 1:1 close monitoring to resident #001. RN #147 left resident #001 unattended in an identified area to assist another resident in their room. Resident #001 got up and walked only a few steps and had a third fall with no injury.

Review of resident #001's clinical record did not identify a completed neurological assessment at identified times for the falls, as per the home's policy Fall Risk Management, revised April 20, 2015, directed them to do.

In an interview, PSW #148 indicated that the resident returned to the home at the time staff were to start their rounds. They assisted paramedics to settle the resident. The PSW acknowledged being aware that the resident never wanted to sit or sleep in an identified location during the night. The PSW indicated that before the second fall, they checked on resident #001 and noted that the resident was awake. The resident had a responsive behaviour when staff tried to make them comfortable, but they believed that the resident would stay in the identified location as they were in pain from the injury. The PSW said they left the resident to assist other residents and was checking on the resident every 20 minutes, because they could not find the float PSW to monitor the resident closely by providing 1:1. The resident had a second fall.

RPN #139 indicated that they kept an eye on the resident and let them be, and provided supervision, as they could not restrain the resident.

In an interview, RPN #139 indicated that when the resident returned from the hospital, the resident was sleeping and staff were about to start their rounds. The paramedics put the resident in an identified location and told them that the resident was sedated for the treatment of the injury. The RPN indicated that they were aware that the resident never slept in an identified location during night shift

and the resident was to be monitored closely. The PSW was to check the resident every 20 minutes as the RPN had three units with 79 residents, they were not aware if the PSW checked on the resident. The RPN also indicated that the float PSW was busy with other residents so they were not able to provide 1:1.

In an interview, RN #147 indicated that they were informed during their shift report that the resident had fallen and needed to be monitor closely. As the unit was short of one PSW, they stayed with the resident and provided 1:1. The RN indicated that they were called by the RPN for assistance and they left resident #001 unattended in an identified area and stepped away for a period of five to ten minutes. During that time resident #001 had the third fall.

From the record review and staff interview, staff of the home were aware that the resident had an unsteady gait, was sedated and that they would try to get up as soon as they were awake. A review of the resident's plan of care did not identify strategies to reduce the risk of falling after the first fall and the staff did not comply with the 1:1 strategy after the second fall.

In an interview, MLTC indicated that registered nurses have the skills and knowledge to assess the situation and implement strategies to prevent recurrence. If they are short staff, the expectation is for the registered staff to contact the administrator on call and ask if there were additional staff in the building that can provide assistance. The MLTC acknowledged that the staff demonstrated a pattern of inaction that jeopardized the health or safety of resident #001. The staff did not contact the administrator on call when they were short staff and unable to provide 1:1. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

(a) A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #060 reported to a family member during their visit that they fell.
The inspector tried to interview the resident but they were not interviewable.

A review of the home's transfer policy titled Minimal lift and client/resident handling indicated on page two under the definition of lift states: A lift is performed mechanically using a lifting device, (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

(i) A review of the home's video surveillance on an identified date, clearly indicated that PSW #197 had transferred resident #060 by themselves, as they were the only PSW seen on the surveillance recording taking the resident into their room.

In an interview with PSW #197, they acknowledged that they had completed the resident's transfer alone.

(ii) On another identified date PSW #201 was observed on the home's video surveillance taking the mechanical lift out of resident's #060 room. A second staff member was never seen entering the room during this time, therefore the inspector has concluded that the resident was unsafely transferred if only one staff operated the mechanical lift to transfer the resident.

In a letter obtained from the home, addressed to PSW #201, it indicated that the home concluded that resident #060 was transferred alone by PSW #201 on an

identified date. A significant trauma had occurred during the resident transfer which they had failed to report, resulting in the resident not receiving any treatment for several days for an injury.

(iii) On another identified date, according to the home's video surveillance, resident #060 was taken to their room and put to bed. Three PSWs were later seen exiting the resident's room. The mechanical lift was observed in the hallway outside the resident's room and never left this area when the three PSWs went into the resident's room to assist with the transfer of the resident. Therefore, the inspector concluded that the resident was not safely transferred if the mechanical lift was not used.

In an interview with PSW #131 who had been in the resident's room when the resident was transferred back to bed, told the inspector that the mechanical lift had not been used to transfer the resident back to bed. According to PSW #131 the resident was lifted by PSW #201 and they had assisted with lifting the resident's feet. PSW #131 acknowledged that safe transferring and positioning technique had not been used.

In an interview with MLTC #149, they acknowledged that unsafe transfer and positioning techniques had not been used when resident #060 had been transfer on the above mentioned occasions.

The DRCE was informed that safe transferring and positioning techniques had not been used on the above mentioned dates when resident #060 was transferred.

(b) A complaint was submitted to the MOHLTC alleging that a staff member had transferred resident #061 by themselves with the lift, resulting in the resident falling and sustaining injuries.

Interview with the resident's family member indicated that they had been notified by the home on an identified date, that the resident had an identified responsive behaviour during care, resulting in them hitting themselves and sustaining an injury on an identified area. The family member further stated that when they visited the resident the next day, they observed a second injury on an identified area. During their visit with the resident the family member identified a second injury on another identified area which they immediately brought to the home's attention.

A review of the home's transfer policy titled Minimal lift and client/resident handling indicated on page two under the definition of lift states: A lift is performed mechanically using a lifting device, (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

Resident #061 was not interviewable.

In an interview with PSW #110, they told the inspector they had only assisted PSW #111 one time with resident #061 transfer, and was not aware of the resident hitting themselves. According to PSW #110 they had not assisted with any other transfers involving resident #061.

In interviews with RN #102, RPN #108, and PSW#101, they all stated they had never assisted PSW #111 with the transfer of resident #061. The same was confirmed in the home's investigation notes.

According to a written letter from the home to PSW #111, it indicated that they had transferred the resident several times during their shifts on identified dates, and only on one occasion they transferred resident #061 with a second staff.

PSW #111 actions on the identified dates, of transferring resident #061 several times by themselves indicated that safe transferring and positioning devices had not been used during the resident transfers.

In an interview with the DRCE, in response to if safe transferring and positioning techniques were used they acknowledged that they were likely not safe.

(c) While conducting an observation on March 28, 2019, between 1230 and 1255 hours on a home area, the inspector observed a private care companion applying a sling to a resident who was sitting in their wheelchair in the corridor at the end of the hallway.

The inspector had a brief conversation with the private care companion #150 who was with resident #018. In response to when was the last time they helped to transfer the resident they identified a day within the week, and identified PSW #118 as the staff member who they had helped to transfer the resident after lunch to be changed using the mechanical lift. In response to if this was the only time that they had helped with the resident's transfer they told the inspector that they had helped sometimes when the resident had been given an identified medication

and could not wait to go.

During a follow up interview with private care companion #150 on a later date, they told the inspector they have not been trained on how to apply the resident's sling. They acknowledged they had been the second person during resident #018's transfer but could not recall when and stated they had only done so once before with PSW #118.

The home's policy titled Minimal lift and client/ resident handling indicated on page two under definition of lift states: A lift is performed mechanically using a lifting device, (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

The home's policy was not followed and safe transferring and positioning techniques had not been used when assisting resident #018 with a transfer.

In an interview with PSW #118, they told the inspector they had transferred resident #018 with private care companion #150 last month only in an emergency. They explained that the private care companion would hold the resident's back because the other PSW could not leave the dining room. They acknowledged that the home's policy had not been followed as it had to be two home's staff. The private care companion was not allowed to assist with the resident's transfer. PSW #118 acknowledged that safe transferring and positioning techniques had not been used.

In an interview with MLTC #145, they explained their expectation is to have two employees transfer the resident during transfers.

(d) A CIS report was submitted to the MOHLTC involving resident #004.

Further review of the CIS report indicated that resident #004 sustained a fall on an identified date that resulted in an injury. The home conducted an investigation and identified that the contributing factor to the resident's fall was related to the assigned PSW not following the resident's transfer requirement as they had performed the transfer by themselves rather than with two staff.

A review of the home's transfer policy titled Minimal lift and client/resident handling indicated on page two under definition of lift states: A lift is performed mechanically using a lifting device (i.e. ceiling lift, standing lift). At least two

trained staff members are required to operate the lifting device.

Interview with PSW #119 and review of the home's investigation notes indicated that PSW #119 had transferred resident #004 by themselves on an identified date and had been transferring the resident by themselves since they came to the home. PSW #119 explained to the inspector that because they had been transferring the resident by themselves they had not noticed that they were a two person side by side transfer. The inspector asked about the transfer logo posted in the resident's room and they responded that they had never checked the resident's care plan if anything had changed or got any report of a change and knew of the transfer logo being there but had not looked at it.

In an interview with MLTC #116, they explained that the PSW was advised of the home's expectation and was quite remorseful, they demonstrated an understanding going forward that they would follow the home's transfer requirements. PSW #119 was disciplined for putting the resident at risk and not following the resident's care plan.

Due to PSW #119's admission of transferring resident #004 by themselves instead of with the mechanical standing lift with two staff using indicated that unsafe transferring and positioning techniques were used with resident #004

(e) A CIS report was submitted to the MOHLTC related to fall with injury.

Review of the CIS report and progress notes indicated that on an identified date, resident #003 was found in an identified location of the home. On a later date the resident expressed pain to an identified area, the attending physician ordered an x-ray, which the results indicated an injury to an identified body area, and the resident was transferred to the hospital.

Review of Transfer Logo training material indicated under change in transfer status indicated that - If a resident's transfer status changes or staff are having trouble transferring them based on the logo - let the RPN know.
Registered staff
- inform PT to re-assess transfer status
- can downgrade transfer status (1-person transfer to 2-person transfer; 2-person transfer to Hoyer lift)
- use of mechanical lift must be assessed by PT.

On April 10, 2019, at 1020 hours, Inspector #502 observed the resident sitting in the wheelchair, out from the washroom and PSW #151 pushing the mechanical lift out of the room.

In interviews PSWs #151 and #152 indicated that they used the mechanical lift to transfer the resident from the mobility device to toilet and to provide a shower to the resident. Both PSWs also indicated that they usually use the mechanical lift to get the resident standing up to provide care as it was difficult to wash when the resident was sitting on a commode above the toilet bowl during the shower.

In an interview, PT #157 indicated that the mechanical lift can only be used to transfer the resident from one surface to other surface, but not as support to get the resident standing during care. PT #157 indicated that prior to the use of a mechanical lift they had to assess resident #003's weight bearing capacity, trunk control, cognition, and shoulder range of motion. PT #157 indicated if the resident had declined, staff are expected to downgrade the resident transfer from one person assist to two person assist, or from two person assist to Hoyer lift. If the resident was consistently not doing well registered staff are expected to send a referral for re-assessment.

PT #157 and MLTC #145 indicated that both PSWs had not used safe techniques when assisting resident #003 during their shower as the PT had not re-assessed the resident prior the use of mechanical lift. [s. 36.] (502)

(f) A CIS report was submitted to the MOHLTC related to injury with unknown cause. Review of the CIS report indicated that an injury was noted on resident #002 on two identified areas.

Review of the progress notes indicated that on an identified date, the assigned PSW reported an injury on identified area of resident #002. Upon assessment the registered staff documented that the resident had an injury on two identified areas. The resident was grimacing and held onto an identified area when registered staff attempted to assess.

In an interview, PSW #154 indicated that on an identified date, they provided care to resident #002. The PSW indicated that the resident required a Hoyer lift with two person assistance for all transfers. PSW #154 indicated that after the dinner service on the day of the incident, resident #002 was seated among co-residents and had an offensive odour. The PSW stated that they pushed resident #002 into

their room and noted that the resident was incontinent. PSW #154 indicated that they used the Hoyer lift without assistance of another staff as other PSWs were on break. PSW #154 also indicated that they used an inappropriate sling as they were told that the sling was too small for the resident. PSW #154 indicated that they were disciplined.

In an interview, MLTC #149 acknowledged that PSW #154 had not used safe transferring techniques when assisting resident #002. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 002

Issued on this 16th day of July, 2019 (A2)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JOY IERACI (665) - (A2)
Inspection No. / No de l'inspection :	2019_751649_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000722-19, 001094-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 16, 2019(A2)
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, TORONTO, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Simon Akinsulie

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To The Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 19. (1).

Specifically, the licensee shall ensure that resident #060 and #001 are not neglected by the licensee or staff.

Upon receipt of this compliance order the licensee shall ensure:
1. Direct care staff report all incidents of abuse and/ or neglect of residents in the home.

2. Development and implementation of informal weekly discussions with direct care staff on all shifts about the importance of identifying and reporting incidents of abuse and/ or neglect of residents. This documented discussion should include full-time, part-time, and casual direct care staff. Document weekly discussions by way of an attendance list.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that residents #060 and #001 were not neglected by the licensee or staff.

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

(a) A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #060 reported to their son during their visit on January 6, 2019, that they fell from the bed.

According to the complainant, the resident's son immediately inquired with the nursing staff who denied that the resident fell and reported they were unwell and had been in bed for the last few days. The resident also reported to the complainant and the resident's son that there were a lot of people who helped them back to the bed and specifically identified PSW #201. The resident told the complainant and their son that they had hit their head on the floor. The resident's son examined the resident's head but did not observe a bruise.

Record review indicated that resident #060 was non-ambulatory and used a wheelchair for locomotion and a mechanical lift for transfers. Further review indicated there was a communication barrier as the resident's first language was not English and they had difficulty with hearing. Interviews indicated that the resident enjoyed spending time up in their wheelchair in the hallway where they could see people and always requested to have a wet towel on their head due to an identified medical condition. According to the resident's resident assessment instrument – minimum data set (RAI-MDS) assessment dated December 10, 2018, the resident had a cognitive performance scale (CPS) score of three out of six indicative of moderate impairment.

The inspector tried to interview the resident (using MCIS interpretation services) but they were not interviewable. Voice recordings were obtained and reviewed of the resident saying that they "flew" from the bed and hit the floor and had pain in their head.

According to the complainant, on January 7, 2019, the resident was visited by a friend (#198) who they told that their head hurt, and they fell from the bed. Once again the resident identified PSW #201 as the person who helped them back to the bed. In an interview with the resident's friend (using MCIS interpretation services) they reported that the resident was in bed when they visited them and was told by staff that the resident had a headache. The resident's friend #198 tried to help the resident to sit up in bed but they started to scream don't touch me it is painful.

The complainant told the inspector that on January 8, 2019, resident #060's son was

contacted by the resident's physician (#200) and they asked why the resident was not in their wheelchair as usual and was in bed. They expressed concern about this to the physician and that the resident had reported that they fell from the bed. According to the complainant, the physician did not have any report of the resident falling but was going to look into it. The resident's son was once again contacted by the resident's physician on the same day, who told them they were sending the resident to the hospital as it appeared the resident may have had a heart attack or stroke. The resident was transferred to hospital on January 8, 2019 for further assessment.

The complainant told the inspector that the resident was assessed by the cardiology and stroke team in hospital and reported that the resident had not suffered a heart attack or stroke but had multiple fractures in their neck.

A review of the hospital consultation report indicated that the resident had sustained acute displaced fractures involving C2 and fractures of bilateral C1 arch, as well as bilateral artery dissection. There was bruising of the resident's arm but no obvious trauma to the arm was identified. The hospital consultation report further stated that this injury was likely the result of an un-witnessed fall.

A review of the resident's #060 progress notes did not indicate any documentation that the resident had suffered a recent fall or any other related injury. The complainant expressed suspicion to the inspector that an accident had occurred on January 3 or 4 as the resident's son was told by the home on January 6, 2019, when they visited that the resident had been in bed for the last couple of days.

On January 3, 2019, according to the 24-hour nursing hand-written report and point click care (PCC) progress notes, resident #060 was put back to bed after lunch because they were not feeling well and was moaning and complaining of undescribed pain. Scheduled pain medication was given. There was no documentation of the site of the resident's pain. Progress notes and staff interviews indicated that resident frequently complain of headaches and requested to have a wet towel on their head.

According to the 24-hour nursing hand-written report documented on the day shift on January 5, 2019, indicated a bruise was identified on the resident's left arm by RPN #194 while they were taking the resident's vitals.

In an interview with RPN #194, they told the inspector the home's process related to the bruise was to report it to the physician, family, manager, and complete a skin assessment in PCC. According to the RPN they had not reported the bruise to the physician, nor to the resident's family, and had not completed a skin assessment in PCC. There was no documentation of the bruise in PCC on January 5, 2019, the RPN made a late entry on January 6, 2019, at 1445 hours related to the bruise on resident's #060 left arm. The RPN told the inspector that they thought that the resident had just bumped their hand and was not suspicious of any other cause.

In an interview with RN #202 who worked on January 5, 2019, when the bruise was initially identified on the resident's left hand, they told the inspector that they had assessed the bruise and indicated that it was approximately the size of their palm. According to RN they had not documented their assessment and told the inspector that they delegated this task to RPN #194. The inspector asked if they had followed up the following day when they work they responded that they knew the RPN would always put a note in the doctor's book and had not asked them because they thought the RPN knew.

According to the 24-hour nursing hand-written report the resident remained in bed for the rest of the day on January 3, all day on January 4, 5, 6, and 7, 2019.

In an interview with the resident's physician #200 they had been informed by the home's staff on the morning of January 8, 2019, that the resident had been in bed for the last couple of days and had been refusing to come out. The physician told the inspector that the resident likes to sit in their wheelchair in the hallway. According to the physician when they first examined the resident in bed they were not immediately concerned about any differential strength or leaning towards one side. The physician told the inspector that when the resident was seen sitting in their wheelchair they were tipping to one side and their trunk was towards the right and not completely lateral making them suspicious of a stroke. The physician further explained the resident leaning forward was unusual for this resident who was able to tolerate hours up in the wheelchair. The physician ordered the resident transferred to hospital on January 8, 2019, for further assessment.

The inspector reviewed the home's video surveillance. According to the video surveillance on the morning of January 3, 2019, resident #060 was transferred by

PSW #201 using the mechanical lift by themselves; the resident's care plan and the home's transfer policy states that it should be done with two staff. Further review of the home's video surveillance indicated the following events:
0810 hours – PSW #201 went into resident #060's room.
0813 hours – PSW #201 came out and went back into resident's room.
0817 hours – PSW #196 brought a cart and placed it outside of the resident's room but did not enter the resident's room.
0819 hours – PSW #201 brought the mechanical lift out of resident #060's room, pushed the linen cart further down the hall, and went back into the resident's room.
PSW #201 came out of the room again and went across the hall into another room.
0823 hours – PSW #201 was observed pushing resident #060 in their wheelchair out of the resident's room and stopped at the room entrance.
0827 hours – PSW #196 took the resident to the dining room.
A second PSW was never seen entering the resident's room on the morning of January 3, 2019, to assist with the resident's mechanical lift transfer.

In an interview with PSW #201, who was seen in the home's video surveillance on the morning of January 3, 2019, bringing the resident out of their room told the inspector they were not assigned to resident #060 on that day, it was PSW #131's assignment. According to PSW #201 while they were walking past resident #060's room they saw that the resident wanted to get up from the bed as their feet were hanging off the bed, from below the knee. The inspector asked if they provided any assistance when they observed the resident's feet off the bed and they responded that they had not. The PSW further explained that they had gone into the resident's room and spoken with the resident asking them to wait for five minutes and the resident nodded their head. According to the PSW they did not provide any assistance to the resident at this time as they knew it was the resident's shower day. The PSW told the inspector that they had provided care and transferred resident #060 with PSW #196 on the morning of January 3, 2019. The inspector showed PSW #201 the home's video surveillance on the morning of January 3, 2019, which showed that PSW #196 was never seen entering resident #060's room to assist them with the transfer. Inspector explained to PSW #201 how the video time was recorded and that they had obtained the video surveillance directly from the home's manager, security telecommunication & emergency prepardness. PSW #201 continued to insist that PSW #196 was in resident #060's room and had helped with care and the transfer of the resident on the morning of January 3, 2019, even though it was clearly seen in the video surveillance that they had never entered the resident's room. PSW

#201 suggested that part of the video may have been removed. PSW #201 denied transferring resident #060 by themselves on the morning of January 3, 2019, and denied that the resident had sustained any fall or injury.

In a letter obtained from the home dated March 22, 2019, addressed to PSW #201, it indicated they had been terminated. The letter further stated that according to the home's video surveillance a second staff was never seen assisting with the resident's transfer on morning of January 3, 2019. The letter stated that throughout the home's investigation PSW #201 had been dishonest about the events on the morning of January 3, 2019. According to the letter the home concluded that PSW #201 had transferred resident #060 by themselves on the morning of January 3, 2019, and a significant trauma had occurred during the resident transfer which they had failed to report, resulting in the resident not receiving any treatment for five days for a fractured neck.

In an interview with PSW #196, on February 26, 2019, they initially told the inspector that the resident was in bed when PSW #201 had asked for their help on January 3, 2019. According to PSW #196 when they first saw the resident they were sitting at the edge of the bed just about to be transferred and was leaning forward. PSW #196 told the inspector that they were on orientation and this was their last day of orientation and had not worked with resident #060 independently until January 7, 2019. A review of the staffing schedule for the period of January 2 to 8, 2019, indicated that January 3, 2019, had been the first day that PSWs #201 and #196 were assigned. The inspector asked what assistance did the resident require with the transfer and PSW #196 explained that the resident would hold onto the rail, while they applied the sling. According to PSW #196 they were asked by PSW #201 to bring the standing lift, which was in the resident's washroom. PSW #196 denied having any knowledge of resident #060 slipping or falling on the morning of January 3, 2019, and told the inspector they were only there in the resident's room when they were sitting on their bed.

In a follow up interview with PSW #196 on March 6, 2019, the inspector showed them the home's video surveillance for the morning of January 3, 2019. They responded that they do remember helping PSW #201 but could not recall if it was on that day as they had not seen themself in the video surveillance leaving the resident's room. The inspector read PSW #196's response from their previous interview on February 26, 2019, and they acknowledged that their statement to the

inspector was different from what they saw in the video surveillance. When the inspector asked if they had assisted with the resident transfer on the morning of January 3, 2019, they responded that they did not see themself coming out of the resident's room. The home's video surveillance clearly showed that PSW #196 was never in the resident's room, the staffing schedule showed January 3, 2019, was the first time that these two staff had worked together, and the documentation indicate when the resident was put back to bed on January 3, 2019, they never got up again until January 8, 2019, when they were transferred to hospital.

The inspector was unable to determine what events had occurred that led to resident #060 being diagnosed at the hospital with acute displaced fractures involving C2 and fractures of bilateral C1 arch, as well as bilateral artery dissection.

In an interview with MLTC #149, who was part of the home's investigation, they told the inspector that no fall had been identified during the home's investigation and staff interviews. The manager told the inspector that the staff did not follow the home's transfer policy of two staff for transfer when the mechanical lift was used once on the evening of January 2 as well as twice on day shift of January 3, 2019; in the morning before breakfast and after lunch. When asked about the resident's current status, the MLTC explained that the resident now has a g-feed. In response to the question if resident #060 had been neglected if PSW #201 had failed to report that the resident had sustained an injury on January 3, 2019, the manager acknowledged that neglect had occurred.

The Director of Resident Care and Experience (DRCE) was informed about the allegation of neglect related to resident #060.

PSW #201 actions of failing to report that the resident had sustained an injury on the morning of January 3, 2019, resulted in the resident not receiving any treatment for five days further to this diagnosed with a fractured neck clearly indicate that the resident had been neglected.

(b) On February 4, 2019, Critical Incident System (CIS) #2824-000005-19 was submitted to the MOHLTC related to falls with injury.

A review of the CIS indicated that on February 2, 2019, at 2120 hours, resident #001 was found lying outside their room. The resident had skin lacerations to their head

and a seven centimetres (cms) deep skin cut to the back of their head. The resident was transferred to the hospital for further assessment and returned to the home on February 3, 2019, at 0415 hours.

Review of the plan of care in effect at the time of the fall incident indicated that resident #001 was at high risk of falls. The plan of care indicated that the resident's risk of falling was related to the resident standing up independently as they were unstable. The plan of care also indicated that if the resident wants to get out of the chair that means they need to go to the toilet.

Record review and staff interview identified that the resident was known to get out of bed and walk unassisted and had an unsteady gait.

Review of the Resident's Safety Event Reporting System (SERS) and the progress notes indicated that on February 03, 2019, at 0415 hours the resident returned to the home confused and disoriented. The paramedics informed the staff that the resident was sedated and they transferred the resident to bed. A post fall strategy to prevent recurrence was not identified.

On February 03, 2019, at 0600 hours the resident had a second fall one hour and forty minutes after they returned from the hospital. This fall resulted in small bleeding on the previous laceration on top of their head, which was stapled in the hospital. The resident had difficulty walking and was in pain whenever they moved their leg. A post fall strategy to prevent recurrence, included monitoring of the resident closely by providing one-on-one (1:1).

On February 03, 2019, at 0840 hours, RN #147 was assigned to provide 1:1 close monitoring to resident #001. RN #147 left resident #001 unattended in the dining room to assist another resident in their room. Resident #001 got up and walked only a few steps and had a third fall with no injury.

Review of resident #001's clinical record did not identify a completed neurological assessment at 0700 hours, 0800 hours, 1000 hours, 1400 hours, 1800 hours, 2200 hours, 0200 hours and 0600 hours for the un-witnessed fall at 2120 hours and 0600 hours respectively, as per the home's policy Fall Risk Management, revised April 20, 2015, directed them to do.

In an interview, PSW #148 indicated that the resident returned to the home at the time staff were to start their rounds. They assisted paramedics to settle the resident in their bed. The PSW acknowledged being aware that the resident never wanted to sit or sleep in their bed during the night. The PSW indicated that before the second fall, they checked on resident #001 and noted that the resident was awake in bed. The resident fought them when they tried to make them comfortable, but they believed that the resident would stay in bed as they were in pain and was bleeding on the head. The PSW said they left the resident to assist other residents and was checking on the resident every 20 minutes, because they could not find the float PSW to monitor the resident closely by providing 1:1. The resident had a second fall.

RPN #139 indicated that they kept an eye on the resident and let them be, and provided supervision as they could not restrain the resident.

In an interview, RPN #139 indicated that when the resident returned from the hospital at 0430 hours, the resident was sleeping and staff were about to start their round. The paramedics put the resident in their bed and told them that the resident was sedated due to the staples on their head. The RPN indicated that they were aware that the resident never slept on their bed during night shift and the resident was to be monitored closely. The PSW was to check the resident every 20 minutes as the RPN had three units with 79 residents, they were not aware if the PSW checked on the resident. The RPN also indicated that the float PSW was busy with other residents so they were not able to provide 1:1.

In an interview, RN #147 indicated that they were informed during their shift report that the resident had fallen and needed to be monitor closely. As the unit was short of one PSW, they stayed with the resident and provided 1:1. The RN indicated that they were called by the RPN for assistance and they left resident #001 unattended in the dining room and stepped away for a period of five to ten minutes. During that time resident #001 had the third fall in the dining room.

From the record review and staff interview, staff of the home were aware that the resident had an unsteady gait, unbalance, was sedated and that they would try to get up as soon as they were awake. The resident only goes to their room to use the toilet and never sleep in their bed. The review of the resident's plan of care did not identify strategies to reduce the risk of falling after the first fall and the staff did not comply with the 1:1 strategy after the second fall.

In an interview, MLTC indicated that registered nurses have the skills and knowledge to assess the situation and implement strategies to prevent recurrence. If they are short staff, the expectation is for the registered staff to contact the administrator on call and ask if there were additional staff in the building that can provide assistance. The MLTC acknowledged that the staff demonstrated a pattern of inaction that jeopardized the health or safety of resident #001. The staff did not contact the administrator on call when they were short staff and unable to provide 1:1.

The severity of this non-compliance was identified as actual harm, the scope was identified as isolated. Review of the home's compliance history revealed a compliance order (CO) was issued on July 27, 2017, under inspection report #2017_486653_0012 for the non-compliance with the LTCHA, 2007 O.Reg. 79/10, s.19. Due to the severity of actual harm and previous non-compliance, a CO is warranted.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019(A2)

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

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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 36.

Specifically, the licensee shall ensure that staff used safe transferring and positioning devices of techniques when assisting residents #060, #061, #018, #004, #003, and #002 and any other residents.

Upon receipt of this compliance order the licensee shall ensure:
1. That two trained staff assist residents who requires a mechanical lift for transfer.

2. Development of documentation, and implementation of random quality improvement audits to be completed during the day, evening, and weekend shifts on all home areas.

3. The designation of a staff member to be most responsible for completing the audits on a weekly basis.

4. Development of documentation by way of an attendance list training/ in service for all registered staff related to their role and responsibilities to supervise PSWs while providing care including safe transfer of residents.

5. That resident #003 and all other applicable residents be assessed by either OT or PT to ensure PSWs are not inappropriately using the sit-to stand lift to support the resident during care. A record of the assessment must be maintained.

Grounds / Motifs :

(A1)
1. The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

(a) A complaint was submitted to the MOHLTC alleging that resident #060 reported to family member during their visit on January 6, 2019, that they fell from the bed.

Record review indicated that resident #060 was non-ambulatory and used a wheelchair for locomotion and a mechanical lift for transfers. Further review indicated there was a communication barrier as the resident first language was not English and they had difficulty with hearing. Interviews indicated that the resident enjoyed spending time up in their wheelchair in the hallway where they could see people and always requested to have a wet towel on their head due to an identified medical condition. According to the resident's RAI-MDS assessment prior to this incident dated December 10, 2018, indicated that the resident had a CPS score of three out of six indicative of moderate impairment.

The inspector tried to interview the resident but they were not interviewable.

A review of the home's transfer policy titled Minimal lift and client/resident handling indicated on page two under the definition of lift states: A lift is performed mechanically using a lifting device, (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

(i) A review of the home's video surveillance on the evening shift on January 2, 2019, clearly indicated that PSW #197 had transferred resident #060 by themselves, as they were the only PSW seen on the surveillance recording taking the resident into their room.

In an interview with PSW #197, they acknowledged that they had completed the resident's transfer alone on the evening of January 2, 2019.

(ii) On the morning of January 3, 2019, between 0810 to 0823 hours approximately, PSW #201 was observed on the home's video surveillance taking the mechanical lift out of resident's #060 room. A second staff member was never seen entering the room during this time, therefore the inspector has concluded that the resident was

unsafely transferred if only one staff operated the mechanical lift to transfer the resident.

In a letter obtained from the home dated March 22, 2019, addressed to PSW #201, it indicated that the home concluded that resident #060 was transferred alone by PSW #201 on the morning of January 3, 2019. A significant trauma had occurred during the resident transfer which they had failed to report, resulting in the resident not receiving any treatment for five days for a fractured neck.

(iii) On January 3, 2019, according to the home's video surveillance, resident #060 was taken to their room after lunch and put to bed between 1238 to 1244 hours approximately. Three PSWs were later seen exiting the resident's room. The mechanical lift was observed in the hallway outside the resident's room and never left this area when the three PSWs went into the resident's room to assist with the transfer of the resident. Therefore, the inspector concluded that the resident was not safely transferred if the mechanical lift was not used.

In an interview with PSW #131 who had been in the resident's room when the resident was transferred back to bed after lunch on January 3, 2019, they told the inspector that the mechanical lift had not been used to transfer the resident back to bed. According to PSW #131 the resident was lifted by PSW #201 and they had assisted with lifting the resident's feet. PSW #131 acknowledged that safe transferring and positioning technique had not been used.

In an interview with MLTC #149, they acknowledged that unsafe transfer and positioning techniques had not been used when resident #060 had been transfer on the evening of January 2, morning of January 3, and after lunch on January 3, 2019.

The DRCE was informed that safe transferring and positioning techniques had not been used on the above mentioned dates when resident #060 was transferred.

(b) A complaint was submitted to the MOHLTC on December 10, 2018, alleging that a staff member had transferred resident #061 by themselves with the lift, resulting in the resident falling and sustaining injuries.

Interview with the resident's family member indicated that they had been notified by the home on Saturday December 8, 2018, that the resident had been aggressive

during care, resulting in them hitting themselves and sustaining a bruise on their face. The family member further stated that when they visited the resident on December 9, 2018, they observed a bruise under their left eye. During their visit with the resident on December 9, 2018, the family member identified a bump and bruise on the resident's right side of their head which they immediately brought to the home's attention.

A review of the home's transfer policy titled Minimal lift and client/resident handling indicated on page two under the definition of lift states: A lift is performed mechanically using a lifting device, (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

According to the RAI-MDS dated November 7, 2018, indicated that the resident required total assistance of two staff for transfers and that the resident was to be lifted mechanically. A review of the support action history tab in PCC indicated it was updated on December 7, 2017, to indicate that the resident was two person standing lift.

Resident #061 was not interviewable.

In an interview with PSW #110, they told the inspector they had only assisted PSW #111 one time with resident #061 transfer, on the morning of December 8, 2018, and was not aware of the resident hitting themselves. According to PSW #110 they had not assisted with any other transfers involving resident #061 again on December 8 and 9, 2018.

In interviews with RN #102, RPN #108, and PSW#101, they all stated they had never assisted PSW #111 with the transfer of resident #061 on December 8 and 9, 2018. The same was confirmed in the home's investigation notes.

According to a written letter from the home to PSW #111 dated January 18, 2019, it indicated that they had transferred the resident five times during their shifts on December 8 and 9, 2018, and only on one occasion they transferred resident #061 with a second staff. This incident along with another incident resulted in PSW #111's termination of employment.

PSW #111 actions on December 8 and 9, 2018, of transferring resident #061 several

times by themselves indicated that safe transferring and positioning devices had not been used during the resident transfers.

In an interview with the DRCE, in response to if safe transferring and positioning techniques were used they acknowledged that they were likely not safe.

(c) While conducting an observation on March 28, 2019, between 1230 and 1255 hours on Red Bird/ Floral Place on the seventh floor, the inspector observed a private care companion applying a sling to a resident who was sitting in their wheelchair in the corridor at the end of the hallway.

On the same day at approximately 1430 hours the inspector had a brief conversation with the private care companion #150 who was with resident #018. In response to when was the last time they helped to transfer the resident, they told the inspector Monday (March 25, 2019), and identified PSW #118 as the staff member who they had helped to transfer the resident after lunch to be changed using the standing lift. In response to if this was the only time that they had helped with the resident's transfer they told the inspector that they helped sometimes when the resident had been given a laxative and could not wait to go.

During a follow up interview with private care companion #150 on April 9, 2019, they told the inspector they have not been trained on how to apply the resident's sling. They acknowledged they had been the second person during resident #018's transfer but could not recall when and stated they had only done so once before with PSW #118.

The home's policy titled Minimal lift and client/ resident handling indicated on page two under definition of lift states: A lift is performed mechanically using a lifting device, (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

The home's policy was not followed and safe transferring and positioning techniques had not been used when assisting resident #018 with a transfer.

In an interview with PSW #118, they told the inspector they had transferred resident #018 with private care companion #150 last month only in an emergency. They explained that the private care companion would hold the resident's back because

the other PSW could not leave the dining room. They acknowledged that the home's policy had not been followed as it had to be two home's staff. The private care companion was not allowed to assist with the resident's transfer. PSW #118 acknowledged that safe transferring and positioning techniques had not been used.

In an interview with MLTC #145, they explained their expectation is to have two employees transfer the resident during transfers.

(d) CIS #2824-000058-18 was submitted to the MOHLTC on December 20, 2018 involving resident #004.

Further review of the CIS indicated that resident #004 sustained a fall on December 8, 2018, that resulted in an undisplaced fracture which was confirmed in an x-ray report dated December 12, 2018. The home conducted an investigation and identified that the contributing factor to the resident's fall was related to the assigned PSW not following the resident's transfer requirement as they had performed the transfer by themselves rather than with two staff.

A review of resident #004's care plan at the time of the inspection indicated they had right sided weakness and under transfer to see support action. Review of the support action history tab in PCC updated on November 28, 2018, indicated that the resident required two staff members for transfers with the standing lift on all shifts. The RAI-MDS dated October 11, 2018, also indicated that the resident required extensive assistance of two staff for transfers.

A review of the home's transfer policy titled Minimal lift and client/resident handling indicated on page two under definition of lift states: A lift is performed mechanically using a lifting device (i.e. ceiling lift, standing lift). At least two trained staff members are required to operate the lifting device.

Interview with PSW #119 and review of the home's investigation notes indicated that PSW #119 had transferred resident #004 by themselves on December 8, 2018, and had been pivot-transferring the resident by themselves since they came to the home. PSW #119 explained to the inspector that because they had been transferring the resident by themselves they had not noticed that they were a two person side by side transfer. The inspector asked about the transfer logo posted in the resident's room and they responded that they had never checked the resident's care plan if anything

had changed or got any report of a change and knew of the transfer logo being there but had not looked at it.

In an interview with MLTC #116, they explained that the PSW was advised of the home's expectation and was quite remorseful, they demonstrated an understanding going forward that they would follow the home's transfer requirements. PSW #119 was disciplined for putting the resident at risk and not following the resident's care plan.

Due to PSW #119's admission of pivot transferring resident #004 by themselves instead of with the standing lift with two staff using indicated that unsafe transferring and positioning techniques were used with resident #004

(e) On November 30, 2018, CIS #2824-000054-18 was submitted to the MOHLTC related to fall with injury.

Review of the CIS and progress notes indicated that on November 13, 2018, resident #003 was found in their bedroom near the washroom. On November 28, 2018, the resident expressed pain in the left leg, the attending physician ordered an x-ray, which the results indicated a fracture of left femoral head, resident was transferred to the hospital. The resident had a surgery on their left hip and returned to the home on December 5, 2018.

A review of resident #003's health records indicated that the resident was admitted to the home on September 11, 2018, with a diagnosis that included Osteo-arthrosis and unspecified dementia. The resident risk of fall assessment completed on admission indicated that the resident was at high risk for falls with a score of 18.

A review of resident #003's RAI-MDS assessment dated March 5, 2019, indicated that the resident was moderately impaired with cognitive skills for daily decision making, and a CPS of three out of six. The resident had total dependence on wheelchair with one person assistance for locomotion on unit. The resident was using a wheelchair for mobility since their re-admission to the home after the left hip surgery on December 5, 2018.

Review of resident #003's current written plan of care under focus transfer indicated that resident #003 requires two person manual assistance (through right side), and a

Hoyer lift whenever there is difficulty in weight bearing and the resident was not alert.

Review of Transfer Logo training material indicated under change in transfer status indicated that - If a resident's transfer status changes or staff are having trouble transferring them based on the logo - let the RPN know.
Registered staff
- inform PT to re-assess transfer status
- can downgrade transfer status (1-person transfer to 2-person transfer; 2-person transfer to Hoyer lift)
- use of standing lift must be assessed by PT.

On April 10, 2019, at 1020 hours, Inspector #502 observed the resident sitting in the wheelchair, out from the washroom and PSW #151 pushing the sit-to stand lift out of the room.

In interviews PSWs #151 and #152 indicated that they used the sit-to-stand lift to transfer the resident from chair to toilet and to provide a shower to the resident. Both PSWs also indicated that they usually use the sit-to-stand lift to get the resident standing up to wash the perineal area as it was difficult to wash when the resident was sitting on a commode above the toilet bowl during the shower.

In an interview, PT #157 indicated that the sit-to-stand lift can only be used to transfer the resident from one surface to other surface, but not as support to get the resident standing during care. PT #157 indicated that prior to the use of a sit-to-stand lift they had to assess resident #003's weight bearing capacity, trunk control, cognition, and shoulder range of motion. PT #157 indicated if the resident was weak, staff are expected to downgrade the resident transfer from one person assist to two person assist, or from two person assist to Hoyer lift. If the resident was consistently not doing well registered staff are expected to send a referral for re-assessment.

PT #157 and MLTC #145 indicated that both PSWs had not used safe techniques when assisting resident #003 during their shower as the PT had not re-assessed the resident prior the use of sit-to-stand lift. [s. 36.] (502)

(f) On November 1, 2017, CIS #2824-000042-17 was submitted to the MOHLTC related to injury with unknown cause. Review of the CIS report indicated that a bruise was noted on resident #002's right arm and forehead on October 29, 2017.

A review of resident #002's RAI-MDS assessment dated March 28, 2019, indicated that the resident was severely impaired with cognitive skills for daily decision making, and a CPS of three out of six. The resident was totally dependent on two staff for all transfers and mobility needs.

Review of resident #002's written plan of care in effect at the time of the incident indicated that the resident was admitted to the home on August 16, 2012, with a diagnosis that included Osteoporosis Cerebrovascular accident (stroke), and Dementia other than Alzheimer's disease. The resident was using a wheelchair with two person assistance for all transfers.

Review of the progress notes indicated that on October 29, 2017, the assigned PSW reported a bruise on resident #002's arm. Upon assessment, the registered staff documented that the resident had a bruise on the inner arm and elbow area. The resident was grimacing and held onto their right hand when registered staff attempted to extend the elbow, as the affected arm was contracted, no inflammation or tenderness was noted, and left arm was warmer and more swollen than the right arm.

In an interview, PSW #154 indicated that on October 29, 2017, they provided care to resident #002. The PSW indicated that the resident required a Hoyer lift with two person assistance for all transfers. PSW #154 indicated that after the dinner service on the day of the incident, resident #002 was seated among co-residents and had an offensive odour. The PSW stated that they pushed resident #002 into their room and noted that the resident had a large bowel movement. PSW #154 indicated that they used the Hoyer lift without assistance of another staff as other PSWs were on break. PSW #154 also indicated that they used an inappropriate sling as they were told that the sling was too small for the resident. PSW #154 indicated that they were disciplined.

In an interview, MLTC #149 acknowledged that PSW #154 had not used safe transferring techniques when assisting resident #002.

The severity of this non-compliance was identified as actual harm, the scope was identified as widespread. There is no compliance history related to this legislation. Due to the severity of actual harm and and the scope being widespread a

compliance order is warranted.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019(A2)

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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of July, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JOY IERACI (665) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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