Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2020	2020_633577_0003	024358-19, 000132-20, 000169-20	Complaint

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

DEBBIE WARPULA (577)

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): January 14-17 and 20-24, 2020.

The following intakes were inspected during this Complaint Inspection:
- Two intakes related to a fall and improper/incompetent treatment; and
- One intake related to a fall and unexpected death.

Additionally, Critical Incident System (CIS) Inspection #2020_633577_0004 was conducted concurrently with this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Clinical Manager, Registered Nurses (RNs), Best Practice Registered Nurse (Best Practice RN), Medical Doctor (MD), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a Substitute Decision Maker (SDM).

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, employee files and training records, reviewed relevant health care records, bed assessment records, various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
0 VPC(s)
4 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. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in the plan of care was provided

to the resident as specified in the plan.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. One report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home’s suspicion of neglect concerning the care of resident #001 as it pertained to a specific incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

A review of the home's policy, "Care planning - RC-05-01-01", revised April 2017, indicated that the care plan was a guide that directed care that was to be provided to the resident; it served as a communication tool which promoted safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care.

A review of resident #001’s care plan in place at the time of the specific incident, identified that resident #001 required specific assistance with a particular apparatus; a specific device was to be applied to them when they were in bed, chair and wheelchair; and they were to have assistive devices engaged when they were in bed.

A review of a progress note documented by a practitioner on the physician order sheet, on an identified date, indicated that the practitioner had completed particular assessments for resident #001 and it had indicated particular measurements.

A review of 'Clinical Assessment and outcomes', documented by the practitioner, on an identified date, indicated that resident #001 had been assessed and qualified for a particular treatment.

A review of the home’s “Investigative Report”, on an identified date, indicated that PSW #101 had failed to have followed the resident's care plan, as they had transferred the resident in a specific manner not in accordance with the care plan; they left the resident's bed in a particular manner; they failed to have checked or provided continence interventions to the resident for a specified time; they had not secured a specific device to the resident before leaving the room; they had not provided and secured the resident with their required treatment; and they had not engaged the assistive device.

During an interview with PSW #101, they reported to Inspector #577 that they had transferred resident #001 back to their bed after a particular meal, using a specific apparatus without assistance and had not positioned the bed in a particular position.

During an interview with the Administrator they reported to Inspector #577 that PSW #101 had failed to follow resident #001's care plan. Specifically by having performed a specific transfer by themselves; having left the resident's bed in a particular manner; they had not secured a specific device to the resident; they had not provided and secured the resident with their required treatment and had not engaged the assistive device. [s. 6. (7)]

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. 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 :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. One report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home's suspicion of neglect concerning the care of resident #001 as it pertained to a specific incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program – RC-2-01-01", revised June 2019, indicated that the home was committed to having provided a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. They had zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. The policy had given an example of neglect which described a lack of necessary safety precautions to prevent injury to a resident.

A review of staff interviews contained within the investigation file conducted by the Administrator, Assistant Clinical Manager and Director of Care revealed the following:

- on an identified date, PSW #104 reported that they had responded to the emergency bell and resident #001 was found on the floor in a particular position; an apparatus and the bed was in a particular position;
- on two identified dates, RPN #102 reported that they had responded to the emergency bell and resident #001 was found on the floor in a particular position; a specific apparatus was found positioned underneath them; a particular treatment was not on the resident; and the bed was positioned in a particular manner;
- on two other identified dates, PSW #105 reported that they had responded to the emergency bell and resident #001 had been found on the floor in a particular position, a specific apparatus was found positioned underneath them; the bed was positioned in a particular manner and an assistive device was not engaged; the resident exhibited a physical characteristic, and they initiated a particular treatment;
- on two other identified dates, PSW #101 reported that they transferred the resident back to bed after an identified meal, performed the specific lift by themselves and left the apparatus underneath the resident; they had left the bed positioned in a particular manner, engaged the assistive device and left the room to go assist another resident; they stated that when they had returned to the resident's room, they had found them on the floor, in a particular position; they reported that they had to reposition the resident in a particular way in order to get around the resident and onto the bed and push the emergency bell; they confirmed that the assistive device was not engaged when they

entered the room.

A review of the home's "Investigative Report", on an identified date, completed by Manager Employee Relations #106 and the Administrator indicated that they had conducted an investigation into neglect concerning the care provided for resident #001, who passed away on an identified date, and the care provider PSW #101. The conclusion of the investigation substantiated improper care and neglect as they had violated the Minimal Lift policy and procedure, Falls Management and Least Restraints policies and procedures, and failed to follow the resident's care plan, specifically:
- they performed a particular transfer by themselves;
- they left the resident's bed in a particular position;
- they left a particular apparatus underneath the resident in bed after performing the lift;
- they failed to check or provide continence intervention to the resident over a specified time period;
- they had not secured a specific device to the resident before leaving the room;
- they had not provided and secured the resident with their required treatment;
- they had not engaged an assistive device; and
- they had moved the resident after the specific incident before being assessed by a registered staff member.

a) Ontario Regulation 79/10, s. 36. identifies that every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of the home's policy, "Minimal Lift - HR 7-221", revised September 17, 2019, indicated that two trained staff were required at all times when performing a mechanical lift; after the lift, two staff were required to remove the sling.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised August 2019, indicated that as part of their fall risk reduction and prevention of falls, staff were to have ensured that residents' beds were kept in the lowest position at all times; and they were to have always followed safe resident handling procedures, which included the correct positioning and transfer techniques. When a fall occurred, Personal Support Worker's (PSWs) were required to have stayed with the resident, call for assistance and registered staff would assess the resident prior to moving.

As described in WN #3, PSW #101 failed to follow the Minimal Lift policy by having performed a particular transfer by themselves; they failed to follow the home's Falls

Prevention and Management Program by having left the resident's bed in a particular manner; additionally, they moved the resident after the specific incident, before an RN performed an assessment of the resident. See WN #3 for further details.

b) The LTCHA 2007, s. 6 (7) identifies that every licensee of a long-term care home shall ensure that the care set out in the plan of care was to be provided to the resident as specified in the plan.

As described in WN #1, resident #001’s care plan interventions related to falls, transfers and restraints weren't implemented; despite being required by resident #001's plan of care, PSW #101 failed to apply a specific device, failed to engage an assistive device, failed to ensure particular assistance during a specific transfer. For further details refer to WN #1.

A review of a progress note for an identified date, documented by RPN #102, indicated that they had responded to an emergency bell for resident #001’s room, and upon entering the room, resident #001 was exhibiting a physical characteristic with their particular treatment not applied and with a particular apparatus positioned underneath them.

A review of a progress note for an identified date, documented by RN #103, indicated that resident #001 had been found in their room on the floor with their bed in a particular position and their assistive device was not engaged.

During an interview with RN #103, they reported to Inspector #577 that when they had entered resident #001’s room on an identified date, the bed was positioned in a particular manner; a particular apparatus was underneath them; the assistive device was not engaged; a specific device was not on the resident and wasn't alarming.

During an interview with PSW #104, they reported to Inspector #577 that on an identified date, they had responded to the emergency bell for resident #001, and found the resident with a particular device underneath them; their assistive device wasn't attached to them; they weren’t receiving a particular treatment and the bed was positioned in a particular manner.

During an interview with PSW #105, they reported to Inspector #577 that on an identified date, they had responded to the emergency bell for resident #001 and reported that the resident was on the floor in a particular position with a particular device underneath them;

they weren't receiving their specific treatment, exhibited a physical characteristic and they initiated the specified treatment; a specific device wasn't attached to the resident; the assistive device was not engaged and the bed was positioned in a particular manner.

During an interview with RPN #102, they reported to Inspector #577 that on an identified date, they, PSW #105 and PSW #104 had responded to the emergency bell for resident #001, activated by PSW #101. The resident had been found with a particular device underneath them; their assistive device was not engaged and the bed was positioned in a particular manner; their specific treatment had not been applied and they had applied their treatment.

During an interview with PSW #101, they reported to Inspector #577 that on an identified date, they had transferred resident #001 back to their bed after an identified meal, used a specific lift without assistance; they had left the a particular device underneath the resident, engaged an assistive device, initiated the specific treatment and had not positioned the bed in a particular position. They reported that when they had checked on the resident during a specified time later, the assistive device was not engaged and the resident was on the floor in a particular position; they reported that they repositioned the resident and pulled the emergency bell for assistance.

During an interview with the Administrator, they confirmed with Inspector #577 that PSW #101 was negligent in their care of resident #001. They had not complied with the home's Minimal Lift policy, Least Restraints policy, Falls Prevention policy and failed to have followed the resident's care plan. Specifically they had performed a specific transfer by themselves; they left the resident's bed in a particular position; they left a particular device underneath the resident in bed after performing the transfer; they failed to check or provide continence interventions to the resident for a specified time. They had not secured a specific device to the resident before leaving the room; they had not provided and secured the resident with their required treatment; they had not engaged the assistive device; and they had moved the resident after the fall before the resident had been assessed by a registered staff member. [s. 19. (1)]

2. Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specific incident and suffered an injury. The one report indicated that the resident was found on the floor in a particular position at a specified time, and was transferred back to bed without the assistance of a specific equipment. The report further indicated that during the transfer, the resident could not engage in a certain activity and was later transferred to the hospital for an assessment.

The second report indicated improper/incompetent care of the resident, as it pertained to the specific incident.

A review of resident #007's care plan interventions related to a particular focus, indicated that the resident required assistance with continence at identified times.

A review of the home's investigation notes indicated the following:
-video footage indicated that the resident had been checked and received continence care at an identified time; they were not checked over a specified time period; an emergency bell had been activated by the housekeeper at a specified time;
-an interview with RPN #112 indicated that resident #007 was found on the floor, and they had assisted the resident to a particular position; the resident had complained of pain to an identified area of their body during the transfer;
-an interview with PSW #113 indicated that when they assisted the resident to a particular position, they were in pain;
-an interview with RN #103 indicated that the resident could not perform a particular activity when they assisted them to a particular position; when they assessed the resident after the specific incident, they indicated that an identified area of the resident's body was in a particular position; stated they should have used specific equipment.

A review of the home's internal "Incident Review" related to resident #007's specific incident on an identified date, indicated that at the time of the incident, the resident was assisted to lift themselves off the floor, expressed pain and the inability to perform a particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

A review of the progress notes indicated that RN #110 assessed resident #007 on the subsequent day shift, as the resident had been complaining of pain. They noted that an identified area of the resident's body was in a particular position; the resident stated it was too painful to move the identified area of their body; the physician was called and the resident was transferred to the hospital at a specified time.

As described in WN #3, and CIS #2020_633577_0004, WN #1, PSW #113, RPN #112 and RN #103, failed to follow the Post Fall Clinical Pathway in the Falls Prevention and Management Program, by transferring the resident off the floor without the assistance of specific equipment.

A review of the home's policy, "Care and Comfort Rounds - RC-12-01-06", revised February 2017, indicated that the home scheduled regular care and comfort rounds at set intervals to proactively anticipate resident needs related to pain, positioning, prompted toileting, proximity to personal items and other comfort and safety issues. Appendix 1 of the policy indicated that comfort rounds were scheduled every two hours.

As described in WN #3 of CIS #2020_633577_0004, PSW #113, RPN #112 and RN #103, failed to provide care rounds every hour and had not checked resident #007 over a specified time period; and they failed to provide continence care for resident #007 as per the care plan.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the resident back to bed as a two person transfer without using specific equipment.

During an interview with the Director of Care (DOC), they confirmed that staff had provided negligent care to resident #007; they had not checked resident #007 over a specified time period, and the resident was found on the floor at a specified time; they had not provided safe transfer practices by using a two person transfer from the floor to their bed. They failed to have followed the home's Care and Comfort rounds policy, had not followed the resident's care plan, and failed to have implemented the Fall's program. [s. 19. (1)]

Additional Required Actions:

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

WN #3: 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 residents.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. The one report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home's suspicion of neglect concerning the care of resident #001 as it pertained to the specified incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

A review of resident #001's care plan in place at the time of the incident, included an intervention which indicated that staff were to have used specific equipment for transfers with the assistance of two staff.

A review of the home's policy, "Minimal Lift - HR 7-221", revised September 17, 2019, indicated that two trained staff were required at all times when performing a mechanical lift; after the lift, two staff were required to remove the sling.

The home's investigation notes related to the incident, described an interview on two identified dates, between the home and PSW #101. PSW #101 confirmed that they had used specific equipment without assistance while transferring resident #001 into their bed.

A review of the home's "Investigative Report", on an identified date, indicated that PSW #101 had violated the Minimal Lift policy and procedure as they had performed a two person lift without two staff present.

During an interview with PSW #107, and PSW #108, they reported to Inspector #577 that two staff were required when using a specific lift when transferring residents.

During an interview with PSW #101, they reported to Inspector #577, that on an identified

date, they had used specific equipment without assistance while transferring resident #001 into their bed.

During an interview with RN #103, they reported to Inspector #577 that two staff were required to have used specific equipment when transferring a resident. They confirmed that PSW #101 had not followed the home's Minimal lift policy.

During an interview with the Administrator, they confirmed that PSW #101 had not followed the Minimal Lift policy and confirmed that two staff were required to operate specific equipment in the home. [s. 36.]

2. Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specific incident and suffered an injury. The report indicated that the resident was found on the floor in a particular position at a specified time, and was transferred back to bed without the assistance of specific equipment. The report further indicated that during the transfer, the resident could not perform a specific activity.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised August 2019, indicated on the 'Post Fall Clinical Pathway', that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

The home's investigation notes indicated the following:

-an interview with RPN #112 which indicated that resident #007 was found on the floor, and they had assisted the resident to a particular position; the resident had complained of pain to an identified area of their body during the transfer;
-an interview with PSW #113 indicated that when they assisted the resident to a particular position, they were in pain;
-an interview with RN #103 indicated that the resident could not perform a particular activity when they assisted them to a particular position; when they assessed the resident after the specific incident, they stated that an identified area of the resident's body was in a particular position; stated they should have used specific equipment.

A review of the home's internal "Incident Review" related to resident #007's specific incident on an identified date, indicated that at the time of the incident, the resident was assisted to lift themselves off the floor, expressed pain and the inability to perform a

particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the resident back to bed as a two person lift without using specific equipment.

During an interview with the DOC, they confirmed that within the home's Fall's program, there was a pathway that directed staff to move a resident using specific equipment after a specified incident, following the assessment by the nurse and approval for transfer. They further reported that staff should have used specific equipment when they transferred resident #007 off the floor. [s. 36.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. The one report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home’s suspicion of neglect concerning the care of resident #001 as it pertained to the specified incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

Ontario Regulation 79/10, s. 109 (g) identifies that every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with how the use of restraining in the home will be evaluated to ensure minimizing of restraining, and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

A review of home's policy, "Bed Rail Safety – RC-08-01-09", revised June 2019, indicated that staff were required to complete a “Bed Rail Safety Assessment" quarterly, at minimum, or more often as required based on the changes to the resident's need for bed rail(s).

A review of the home’s policy, "Least Restraints - RC-22-01-01", revised December 2019, indicated that a Restraint Assessment was required upon initiation of a restraint. The Restraint Reassessment tool was required at a minimum quarterly or more often as required, based on changes to the resident's need for a restraint.

Inspector #577 reviewed a document, "Bed Rail Safety Assessment" on a specified date for resident #001. The document indicated that the resident was at risk of specified incidents and could not perform specific activities safely. Interventions included bed in a particular position, specific device within reach, hourly checks, a specific device when in bed or wheelchair; resident's Power of Attorney (POA) requested assistive devices to be

used, and was aware of specific risks. The document indicated that assistive devices in certain locations were to be used.

A review of the home's document, "Restraint Assessment" on a specified date, for resident #001 indicated that assistive devices were to be used, the resident was a fall risk and the POA requested assistive devices for safety.

During record review, Inspector #577 could not locate a "Restraint Reassessment" or a "Bed Rail Safety Assessment" to have been completed after a specified date.

Inspector #577 reviewed a document, "Bed Rail Safety Assessment" on a specified date for resident #002. The document indicated that the resident was at risk of specified incidents and could not perform specific activities safely. They had impaired communication, an inability to understand why assistive devices were in place, and had impaired cognition and judgment; Interventions included bed in a particular position and hourly checks; resident's POA requests top assistive devices to be used, was aware of specific risks. The document indicated that specific assistive devices in certain locations were to be used.

A review of the home's document, "Restraint Assessment" on a specified date, for resident #002 indicated that specific assistive devices were to be used and the POA requested assistive devices for safety.

During record review, Inspector #577 could not locate a "Restraint Reassessment" or a "Bed Rail Safety Assessment" to have been completed after a specified date.

Inspector #577 reviewed a document, "Restraint Inventory – second floor", on a specified date, which indicated that seven residents on that unit used specific assistive devices.

Inspector reviewed, "Bed Rail Safety Assessments" for residents #004, #003, and #005, on a specified date, and found that their assessments had not been completed after a specified date.

In an interview with RN #110 they reported that the "Bed Rail Safety Assessments" and "Restraint Re-assessments" were required to be done by registered staff every three months.

During an interview with the Director of Care (DOC), they reported to Inspector #577 that

the “Bed Rail Safety Assessments” were done initially when the resident was assessed for assistive devices and repeated every quarter; if the assistive devices were considered a restraint, a “Restraint Assessment” was done initially and the “Restraint Reassessment” was done quarterly. They further reported that they had initiated a new bed safety policy in July 2019, and had assigned RN #110 the responsibility of completing “Bed Rail Safety Assessments” and “Restraint Assessments” on those residents who had been assessed as requiring assistive devices; and had been responsible to have continued the assessments. They confirmed that a specific number of residents currently required assistive devices. The Inspector and the DOC reviewed the assessments for resident #001, #002, #003, #004 and #005, last completed on a specified date. They confirmed that a specific number of residents had not had their assessments completed after a specified date.

During an interview with the Administrator, Inspector #577 reviewed the “Bed Rail Safety Assessments” and “Restraint Assessments” that were completed on a specified date. They reported that the Best Practice Registered Nurse #110 was responsible to have initiated those assessments during a specified time, and to have reassessed every quarter, and it was not done. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l’inspection :	2020_633577_0003
Log No. / No de registre :	024358-19, 000132-20, 000169-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 11, 2020
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Bethammi Nursing Home 63 Carrie Street, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Janine Black

To St. Joseph's Care Group, 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 # / No d'ordre : 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. 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).

Order / Ordre :

The licensee must be in compliance with s. 6. (7) of the LTCHA.
Specifically the licensee must:

a) Ensure all resident's plans of care are followed, specifically, but not limited to personal care, monitoring checks and falls prevention interventions.
b) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

1. 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.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. One report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home's suspicion of neglect concerning the care of resident #001 as it pertained to a specific incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

A review of the home's policy, "Care planning - RC-05-01-01", revised April 2017, indicated that the care plan was a guide that directed care that was to be provided to the resident; it served as a communication tool which promoted safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement

strategies to mitigate risk and provide appropriate care.

A review of resident #001's care plan in place at the time of the specific incident, identified that resident #001 required specific assistance with a particular apparatus; a specific device was to be applied to them when they were in bed, chair and wheelchair; and they were to have assistive devices engaged when they were in bed.

A review of a progress note documented by a practitioner on the physician order sheet, on an identified date, indicated that the practitioner had completed particular assessments for resident #001 and it had indicated particular measurements.

A review of 'Clinical Assessment and outcomes', documented by the practitioner, on an identified date, indicated that resident #001 had been assessed and qualified for a particular treatment.

A review of the home's "Investigative Report", on an identified date, indicated that PSW #101 had failed to have followed the resident's care plan, as they had transferred the resident in a specific manner not in accordance with the care plan; they left the resident's bed in a particular manner; they failed to have checked or provided continence interventions to the resident for a specified time; they had not secured a specific device to the resident before leaving the room; they had not provided and secured the resident with their required treatment; and they had not engaged the assistive device.

During an interview with PSW #101, they reported to Inspector #577 that they had transferred resident #001 back to their bed after a particular meal, using a specific apparatus without assistance and had not positioned the bed in a particular position.

During an interview with the Administrator they reported to Inspector #577 that PSW #101 had failed to follow resident #001's care plan. Specifically by having performed a specific transfer by themselves; having left the resident's bed in a particular manner; they had not secured a specific device to the resident; they had not provided and secured the resident with their required treatment and had not engaged the assistive device. [s. 6. (7)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual harm, and the scope which was isolated. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a Written Notification (WN) from a Critical Incident System (CIS) Inspection #2019_740621_0024 on August 20, 2019;
- a Compliance Order from a Resident Quality Inspection (RQI) #2019_768693_0005, on July 10, 2019;
- a Voluntary Plan of Correction (VPC) was issued from a Critical Incident System (CIS) Inspection #2019_703625_0003, on February 8, 2019;
- a VPC was issued from a Follow Up (FU) Inspection # 2018_616542_0015, on September 24, 2018;
- a VPC was issued from a Resident Quality Inspection (RQI) #2018_703625_0001, on March 26,
2018; and
- VPC was issued from a Complaint Inspection #2017_435621_0005, on February 14, 2017.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020

Order # / No d'ordre : 002

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 s. 19. (1) of the LTCHA.
Specifically, the licensee must:

Ensure all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. One report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home's suspicion of neglect concerning the care of resident #001 as it pertained to a specific incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect

Program – RC-2-01-01", revised June 2019, indicated that the home was committed to having provided a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. They had zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. The policy had given an example of neglect which described a lack of necessary safety precautions to prevent injury to a resident.

A review of staff interviews contained within the investigation file conducted by the Administrator, Assistant Clinical Manager and Director of Care revealed the following:

- on an identified date, PSW #104 reported that they had responded to the emergency bell and resident #001 was found on the floor in a particular position; an apparatus and the bed was in a particular position;
- on two identified dates, RPN #102 reported that they had responded to the emergency bell and resident #001 was found on the floor in a particular position; a specific apparatus was found positioned underneath them; a particular treatment was not on the resident; and the bed was positioned in a particular manner;
- on two other identified dates, PSW #105 reported that they had responded to the emergency bell and resident #001 had been found on the floor in a particular position, a specific apparatus was found positioned underneath them; the bed was positioned in a particular manner and an assistive device was not engaged; the resident exhibited a physical characteristic, and they initiated a particular treatment;
- on two other identified dates, PSW #101 reported that they transferred the resident back to bed after an identified meal, performed the specific lift by themselves and left the apparatus underneath the resident; they had left the bed positioned in a particular manner, engaged the assistive device and left the room to go assist another resident; they stated that when they had returned to the resident's room, they had found them on the floor, in a particular position; they reported that they had to reposition the resident in a particular way in order to get around the resident and onto the bed and push the emergency bell; they confirmed that the assistive device was not engaged when they entered the room.

A review of the home's "Investigative Report", on an identified date, completed by Manager Employee Relations #106 and the Administrator indicated that they had conducted an investigation into neglect concerning the care provided for resident #001, who passed away on an identified date, and the care provider PSW #101. The conclusion of the investigation substantiated improper care and neglect as they had violated the Minimal Lift policy and procedure, Falls Management and Least Restraints policies and procedures, and failed to follow the resident's care plan, specifically:
- they performed a particular transfer by themselves;
- they left the resident's bed in a particular position;
- they left a particular apparatus underneath the resident in bed after performing the lift;
- they failed to check or provide continence intervention to the resident over a specified time period;
- they had not secured a specific device to the resident before leaving the room;
- they had not provided and secured the resident with their required treatment;
- they had not engaged an assistive device; and
- they had moved the resident after the specific incident before being assessed by a registered staff member.

a) Ontario Regulation 79/10, s. 36. identifies that every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of the home's policy, "Minimal Lift - HR 7-221", revised September 17, 2019, indicated that two trained staff were required at all times when performing a mechanical lift; after the lift, two staff were required to remove the sling.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised August 2019, indicated that as part of their fall risk reduction and prevention of falls, staff were to have ensured that residents' beds were kept in the lowest position at all times; and they were to have always followed safe resident handling procedures, which included the correct positioning and transfer techniques. When a fall occurred, Personal Support Worker's (PSWs) were required to have stayed with the resident, call for assistance and registered staff would assess the resident prior to moving.

As described in WN #3, PSW #101 failed to follow the Minimal Lift policy by having performed a particular transfer by themselves; they failed to follow the home's Falls Prevention and Management Program by having left the resident's bed in a particular manner; additionally, they moved the resident after the specific incident, before an RN performed an assessment of the resident. See WN #3 for further details.

b) The LTCHA 2007, s. 6 (7) identifies that every licensee of a long-term care home shall ensure that the care set out in the plan of care was to be provided to the resident as specified in the plan.

As described in WN #1, resident #001's care plan interventions related to falls, transfers and restraints weren't implemented; despite being required by resident #001's plan of care, PSW #101 failed to apply a specific device, failed to engage an assistive device, failed to ensure particular assistance during a specific transfer. For further details refer to WN #1.

A review of a progress note for an identified date, documented by RPN #102, indicated that they had responded to an emergency bell for resident #001's room, and upon entering the room, resident #001 was exhibiting a physical characteristic with their particular treatment not applied and with a particular apparatus positioned underneath them.

A review of a progress note for an identified date, documented by RN #103, indicated that resident #001 had been found in their room on the floor with their bed in a particular position and their assistive device was not engaged.

During an interview with RN #103, they reported to Inspector #577 that when they had entered resident #001's room on an identified date, the bed was positioned in a particular manner; a particular apparatus was underneath them; the assistive device was not engaged; a specific device was not on the resident and wasn't alarming.

During an interview with PSW #104, they reported to Inspector #577 that on an identified date, they had responded to the emergency bell for resident #001, and found the resident with a particular device underneath them; their assistive

device wasn't attached to them; they weren't receiving a particular treatment and the bed was positioned in a particular manner.

During an interview with PSW #105, they reported to Inspector #577 that on an identified date, they had responded to the emergency bell for resident #001 and reported that the resident was on the floor in a particular position with a particular device underneath them; they weren't receiving their specific treatment, exhibited a physical characteristic and they initiated the specified treatment; a specific device wasn't attached to the resident; the assistive device was not engaged and the bed was positioned in a particular manner.

During an interview with RPN #102, they reported to Inspector #577 that on an identified date, they, PSW #105 and PSW #104 had responded to the emergency bell for resident #001, activated by PSW #101. The resident had been found with a particular device underneath them; their assistive device was not engaged and the bed was positioned in a particular manner; their specific treatment had not been applied and they had applied their treatment.

During an interview with PSW #101, they reported to Inspector #577 that on an identified date, they had transferred resident #001 back to their bed after an identified meal, used a specific lift without assistance; they had left the a particular device underneath the resident, engaged an assistive device, initiated the specific treatment and had not positioned the bed in a particular position. They reported that when they had checked on the resident during a specified time later, the assistive device was not engaged and the resident was on the floor in a particular position; they reported that they repositioned the resident and pulled the emergency bell for assistance.

During an interview with the Administrator, they confirmed with Inspector #577 that PSW #101 was negligent in their care of resident #001. They had not complied with the home's Minimal Lift policy, Least Restraints policy, Falls Prevention policy and failed to have followed the resident's care plan. Specifically they had performed a specific transfer by themselves; they left the resident's bed in a particular position; they left a particular device underneath the resident in bed after performing the transfer; they failed to check or provide continence interventions to the resident for a specified time. They had not secured a specific device to the resident before leaving the room; they had not

provided and secured the resident with their required treatment; they had not engaged the assistive device; and they had moved the resident after the fall before the resident had been assessed by a registered staff member. [s. 19. (1)] (577)

2. Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specific incident and suffered an injury. The one report indicated that the resident was found on the floor in a particular position at a specified time, and was transferred back to bed without the assistance of a specific equipment. The report further indicated that during the transfer, the resident could not engage in a certain activity and was later transferred to the hospital for an assessment. The second report indicated improper/incompetent care of the resident, as it pertained to the specific incident.

A review of resident #007's care plan interventions related to a particular focus, indicated that the resident required assistance with continence at identified times.

A review of the home's investigation notes indicated the following:
-video footage indicated that the resident had been checked and received continence care at an identified time; they were not checked over a specified time period; an emergency bell had been activated by the housekeeper at a specified time;
-an interview with RPN #112 indicated that resident #007 was found on the floor, and they had assisted the resident to a particular position; the resident had complained of pain to an identified area of their body during the transfer;
-an interview with PSW #113 indicated that when they assisted the resident to a particular position, they were in pain;
-an interview with RN #103 indicated that the resident could not perform a particular activity when they assisted them to a particular position; when they assessed the resident after the specific incident, they indicated that an identified area of the resident's body was in a particular position; stated they should have used specific equipment.

A review of the home's internal "Incident Review" related to resident #007's specific incident on an identified date, indicated that at the time of the incident,

the resident was assisted to lift themselves off the floor, expressed pain and the inability to perform a particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

A review of the progress notes indicated that RN #110 assessed resident #007 on the subsequent day shift, as the resident had been complaining of pain. They noted that an identified area of the resident's body was in a particular position; the resident stated it was too painful to move the identified area of their body; the physician was called and the resident was transferred to the hospital at a specified time.

As described in WN #3, and CIS #2020_633577_0004, WN #1, PSW #113, RPN #112 and RN #103, failed to follow the Post Fall Clinical Pathway in the Falls Prevention and Management Program, by transferring the resident off the floor without the assistance of specific equipment.

A review of the home's policy, "Care and Comfort Rounds - RC-12-01-06", revised February 2017, indicated that the home scheduled regular care and comfort rounds at set intervals to proactively anticipate resident needs related to pain, positioning, prompted toileting, proximity to personal items and other comfort and safety issues. Appendix 1 of the policy indicated that comfort rounds were scheduled every two hours.

As described in WN #3 of CIS #2020_633577_0004, PSW #113, RPN #112 and RN #103, failed to provide care rounds every hour and had not checked resident #007 over a specified time period; and they failed to provide continence care for resident #007 as per the care plan.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the

resident back to bed as a two person transfer without using specific equipment.

During an interview with the Director of Care (DOC), they confirmed that staff had provided negligent care to resident #007; they had not checked resident #007 over a specified time period, and the resident was found on the floor at a specified time; they had not provided safe transfer practices by using a two person transfer from the floor to their bed. They failed to have followed the home's Care and Comfort rounds policy, had not followed the resident's care plan, and failed to have implemented the Fall's program. [s. 19. (1)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated serious harm, and the scope which was a pattern. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a Compliance Order (CO) and a Director Referral (DR) was issued from a Resident Quality Inspection (RQI) #2019_768_0005 on April 15, 2019; and
- a Compliance Order (CO) was issued from a Resident Quality Inspection (RQI) #2018_703625_000, on March 26, 2018. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 003

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 in compliance with Ontario Regulation (O. Reg.) 79/10, r. 36
Specifically the licensee must:

a) Re-train all registered staff and non registered staff on the home's policy, "Minimal Lift - HR 7-221";
b) Ensure that two staff are present when operating all mechanical lifts as per the home's policy;
c) Develop and implement an auditing process to ensure staff adherence to the home's safe transferring and positioning policy; and
d) Maintain records of the training and auditing results and actions taken when the home's safe transferring and lifting policies are breached.

Grounds / Motifs :

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

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. The one report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home's suspicion of neglect concerning the care of resident #001 as it pertained to the specified incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

A review of resident #001's care plan in place at the time of the incident, included an intervention which indicated that staff were to have used specific equipment for transfers with the assistance of two staff.

A review of the home's policy, "Minimal Lift - HR 7-221", revised September 17, 2019, indicated that two trained staff were required at all times when performing a mechanical lift; after the lift, two staff were required to remove the sling.

The home's investigation notes related to the incident, described an interview on two identified dates, between the home and PSW #101. PSW #101 confirmed that they had used specific equipment without assistance while transferring resident #001 into their bed.

A review of the home's "Investigative Report", on an identified date, indicated that PSW #101 had violated the Minimal Lift policy and procedure as they had performed a two person lift without two staff present.

During an interview with PSW #107, and PSW #108, they reported to Inspector #577 that two staff were required when using a specific lift when transferring residents.

During an interview with PSW #101, they reported to Inspector #577, that on an identified date, they had used specific equipment without assistance while transferring resident #001 into their bed.

During an interview with RN #103, they reported to Inspector #577 that two staff were required to have used specific equipment when transferring a resident. They confirmed that PSW #101 had not followed the home's Minimal lift policy.

During an interview with the Administrator, they confirmed that PSW #101 had not followed the Minimal Lift policy and confirmed that two staff were required to operate specific equipment in the home. [s. 36.]

2. Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specific incident and suffered an injury. The report indicated that the resident was found on the floor

in a particular position at a specified time, and was transferred back to bed without the assistance of specific equipment. The report further indicated that during the transfer, the resident could not perform a specific activity.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised August 2019, indicated on the 'Post Fall Clinical Pathway', that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

The home's investigation notes indicated the following:

-an interview with RPN #112 which indicated that resident #007 was found on the floor, and they had assisted the resident to a particular position; the resident had complained of pain to an identified area of their body during the transfer;
-an interview with PSW #113 indicated that when they assisted the resident to a particular position, they were in pain;
-an interview with RN #103 indicated that the resident could not perform a particular activity when they assisted them to a particular position; when they assessed the resident after the specific incident, they stated that an identified area of the resident's body was in a particular position; stated they should have used specific equipment.

A review of the home's internal "Incident Review" related to resident #007's specific incident on an identified date, indicated that at the time of the incident, the resident was assisted to lift themselves off the floor, expressed pain and the inability to perform a particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the

resident back to bed as a two person lift without using specific equipment.

During an interview with the DOC, they confirmed that within the home's Fall's program, there was a pathway that directed staff to move a resident using specific equipment after a specified incident, following the assessment by the nurse and approval for transfer. They further reported that staff should have used specific equipment when they transferred resident #007 off the floor. [s. 36.] (577)

2. Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specific incident and suffered an injury. The report indicated that the resident was found on the floor in a particular position at a specified time, and was transferred back to bed without the assistance of specific equipment. The report further indicated that during the transfer, the resident could not perform a specific activity.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised August 2019, indicated on the 'Post Fall Clinical Pathway', that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

The home's investigation notes indicated the following:

-an interview with RPN #112 which indicated that resident #007 was found on the floor, and they had assisted the resident to a particular position; the resident had complained of pain to an identified area of their body during the transfer;
-an interview with PSW #113 indicated that when they assisted the resident to a particular position, they were in pain;
-an interview with RN #103 indicated that the resident could not perform a particular activity when they assisted them to a particular position; when they assessed the resident after the specific incident, they stated that an identified area of the resident's body was in a particular position; stated they should have used specific equipment.

A review of the home's internal "Incident Review" related to resident #007's specific incident on an identified date, indicated that at the time of the incident, the resident was assisted to lift themselves off the floor, expressed pain and the

inability to perform a particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the resident back to bed as a two person lift without using specific equipment.

During an interview with the DOC, they confirmed that within the home's Fall's program, there was a pathway that directed staff to move a resident using specific equipment after a specified incident, following the assessment by the nurse and approval for transfer. They further reported that staff should have used specific equipment when they transferred resident #007 off the floor. [s. 36.]

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual harm, and the scope which was a pattern. In addition, the home's compliance history identified a history of on on-going unrelated non-compliance. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be in compliance with Ontario Regulation (O. Reg.) 79/10, r. 8 (1) b
Specifically the licensee must:

a) Ensure that all residents who use bed rails, have a completed "Bed Rail Safety Assessment" quarterly, at minimum, or more often as required based on the changes to the resident's need for bed rail(s).
b) Ensure all residents whose bed rails that are considered restraints, have a completed "Restraint Reassessment", at a minimum quarterly or more often as required, based on changes to the resident's need for a restraint.

Grounds / Motifs :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to a specified incident and unexpected death of resident #001. The one report indicated that the resident was transferred to bed, and a specified time later, was found deceased. The second report was related to the home's suspicion of neglect concerning the care of resident #001 as it pertained

to the specified incident.

A subsequent complaint was received by the Director on an identified date, concerning negligent care and the subsequent death of resident #001 related to the specific incident.

Ontario Regulation 79/10, s. 109 (g) identifies that every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with how the use of restraining in the home will be evaluated to ensure minimizing of restraining, and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

A review of home's policy, "Bed Rail Safety – RC-08-01-09", revised June 2019, indicated that staff were required to complete a "Bed Rail Safety Assessment" quarterly, at minimum, or more often as required based on the changes to the resident's need for bed rail(s).

A review of the home's policy, "Least Restraints - RC-22-01-01", revised December 2019, indicated that a Restraint Assessment was required upon initiation of a restraint. The Restraint Reassessment tool was required at a minimum quarterly or more often as required, based on changes to the resident's need for a restraint.

Inspector #577 reviewed a document, "Bed Rail Safety Assessment" on a specified date for resident #001. The document indicated that the resident was at risk of specified incidents and could not perform specific activities safely. Interventions included bed in a particular position, specific device within reach, hourly checks, a specific device when in bed or wheelchair; resident's Power of Attorney (POA) requested assistive devices to be used, and was aware of specific risks. The document indicated that assistive devices in certain locations were to be used.

A review of the home's document, "Restraint Assessment" on a specified date, for resident #001 indicated that assistive devices were to be used, the resident was a fall risk and the POA requested assistive devices for safety.

During record review, Inspector #577 could not locate a "Restraint

Reassessment" or a "Bed Rail Safety Assessment" to have been completed after a specified date.

Inspector #577 reviewed a document, "Bed Rail Safety Assessment" on a specified date for resident #002. The document indicated that the resident was at risk of specified incidents and could not perform specific activities safely. They had impaired communication, an inability to understand why assistive devices were in place, and had impaired cognition and judgment; Interventions included bed in a particular position and hourly checks; resident's POA requests top assistive devices to be used, was aware of specific risks. The document indicated that specific assistive devices in certain locations were to be used.

A review of the home's document, "Restraint Assessment" on a specified date, for resident #002 indicated that specific assistive devices were to be used and the POA requested assistive devices for safety.

During record review, Inspector #577 could not locate a "Restraint Reassessment" or a "Bed Rail Safety Assessment" to have been completed after a specified date.

Inspector #577 reviewed a document, "Restraint Inventory – second floor", on a specified date, which indicated that seven residents on that unit used specific assistive devices.

Inspector reviewed, "Bed Rail Safety Assessments" for residents #004, #003, and #005, on a specified date, and found that their assessments had not been completed after a specified date.

In an interview with RN #110 they reported that the "Bed Rail Safety Assessments" and "Restraint Re-assessments" were required to be done by registered staff every three months.

During an interview with the Director of Care (DOC), they reported to Inspector #577 that the "Bed Rail Safety Assessments" were done initially when the resident was assessed for assistive devices and repeated every quarter; if the assistive devices were considered a restraint, a "Restraint Assessment" was done initially and the "Restraint Reassessment" was done quarterly. They further

reported that they had initiated a new bed safety policy in July 2019, and had assigned RN #110 the responsibility of completing "Bed Rail Safety Assessments" and "Restraint Assessments" on those residents who had been assessed as requiring assistive devices; and had been responsible to have continued the assessments. They confirmed that a specific number of residents currently required assistive devices. The Inspector and the DOC reviewed the assessments for resident #001, #002, #003, #004 and #005, last completed on a specified date. They confirmed that a specific number of residents had not had their assessments completed after a specified date.

During an interview with the Administrator, Inspector #577 reviewed the "Bed Rail Safety Assessments" and "Restraint Assessments" that were completed on a specified date. They reported that the Best Practice Registered Nurse #110 was responsible to have initiated those assessments during a specified time, and to have reassessed every quarter, and it was not done. [s. 8. (1) (b)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated minimal harm, and the scope which was widespread. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a Compliance Order (CO) was issued during Critical Incident System (CIS) Inspection #2019_703625_0003 on February 15, 2019; and
- a Voluntary Plan of Correction (VPC) was issued during Resident Quality Inspection (RQI) #2018_703625_0001 on March 26, 2018. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020

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 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 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 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 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 11th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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