Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 17, 2023	
Inspection Number: 2023-1371-0002	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Montfort, Ottawa	
Lead Inspector Julienne NgoNloga (502)	**Inspector Digital Signature** Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2023.10.17 11:28:31 -04'00'
Additional Inspector(s) Joelle Taillefer (211)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 19, 20, 21, 22, 2023

The following intake(s) were inspected:
- Intake: #00094081 (CIS #2886-000023-23) related to an injury of resident with unknown cause.
- Intake: #00094973 (CIS #2886-000024-23) related to resident-to-resident alleged abuse resulting in an injury.
- Intake: #00095834 (CIS #2886-000029-23) related to alleged neglect of a resident by a staff.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for the resident sets out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary:
A resident's most recent Minimum Data Set (MDS) assessment indicated that the resident was unable to ambulate independently in the unit.

The resident's written care plan indicated that they were at high risk for falls, and used a mobility device without assistance for mobility in the unit. The resident's care plan did not specify the resident locomotion on and off units.

A staff member stated that they were assisting the resident ambulating from the bed to the bathroom with two persons assist side by side. A second staff member indicated that they used one person assist.

A staff member stated that the resident was ambulating with two persons assist as part of the physiotherapy program. However, the residents required a mobility device to ambulate. The staff member stated that the pictogram in the resident's room indicated the method of transfer not the resident's mobility within the unit.

By not providing clear directions in the resident's written plan of care, the resident was put at risk for falls when one or two staff assisted the resident during ambulation without the mobility device.

Sources: A resident's health care records and interviews with three staff members.
[211]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident.

Rationale and Summary
A day in September 2023, the Inspector observed a resident being transferred with a transfer device from bed to toilet.

The resident's fall risk assessment indicated that the resident was at high risk of falls due to a specific condition and cannot stand independently.

The resident's Safe in Ambulation, Lift, and Transfer (SALT) assessment for September 2023, indicated that the resident cannot physically help and cannot weight bear. Based on the home/Arjo lift and transfer decision tree, a second transfer device must be used. However, the resident's plan of care showed that the resident required two staff assistance for transfer with the first transfer device.

As such, the resident's plan of care was not based on the resident assessment posing a potential risk of injury to the resident during transfer.

Sources: Observation of a resident. Review of the resident's health care record.
[502]

WRITTEN NOTIFICATION: Falls prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when the resident has fallen, the resident was assessed and that where the condition or circumstances require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:
A day in August 2023, a resident sustained an injury with unknown cause.

A staff member stated that a day prior to the injury a co-resident told them that the resident fell and got up themselves. The staff member stated that the registered nursing staff was not informed. The resident's health record did not identify a completed post fall assessment for that fall.

As the registered nursing staff was not notified of the resident's fall during the evening shift, the resident's assessment and a post-fall assessment was not conducted.

Sources: A resident's health care records and interviews with two staff members.
[211]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Specifically, the licensee shall:
A- Provide training for all registered nursing staff on home's Safe in Ambulation, Lift, and Transfer (SALT) assessment.

- As part of this training, provide and discuss different types of transfer devices in both languages used in the home.

B - Provide training for all PSWs on the documented method of transfer and mobility for resident.

- As part of the training discuss in both languages used in the home, the pictogram and written plan of care related to residents' transfer and mobility.

C-Keep a documented record of the training, including the date the training was completed, who provided the training and all staff members who attended.

D - Assess three residents transfer need to ensure that the plan of care is based on their assessment

E- Perform audits twice weekly for a period of one months in different resident home areas. The audits shall include resident transfer and mobility, residents' plan of care and pictogram.

F- Keep a documented record of the audits completed and the actions taken based on the audit results.

Grounds

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

A - Rationale and Summary

The Inspector observed two staff members transferred a resident from wheelchair to toilet using a specified transfer device. The resident was unable to weight bear during the transfer.

Review of the resident’s fall risk assessment indicated that the resident was at high risk of falls due to an identified condition and cannot weight bear.

Review of the home’s Resident Lift and Transfer Decision Tree directs staff to use an alternate transfer device if the resident cannot Fully weight bear on at least one leg or partially on both legs and sit independently at end of bed.

Review of the resident’s Safety in Ambulation, Lift, and Transfer (S.A.L.T.) assessment for September 2023, showed that the alternate transfer device must be used as the resident cannot help physically and cannot weight bear.

Interviews with two staff members indicated that they used a specified transfer device during transfer, and the resident remains attached to the device during toileting. Four other staff members indicated that they used the specified transfer device for all the resident's transfers.

A registered staff member indicated that they required additional training to understand the SALT assessment. Physiotherapist (PT) stated that since the assessment forms were written in English, the interpretation of the content was challenging for most of staff of the home.

As such, the resident is put at risk of injury when staff used unsafe transferring device and technique while assisting the resident.

Sources:

Resident's observation. Review of S.A.L.T. assessment, fall risk assessment, Plan of care. Interviews with five staff members.

[502]

B - Rationale and Summary:

A day in August 2023, a resident sustained an injury with unknown cause.

The resident's assessment titled "Safety Assessment, lifts and transfers (SALT-2016)" for August 2023, indicated that the resident was unable to weight bear, and they cannot physically help, therefore a transfer device must be used.

The resident's most recent care plan indicated that the resident required two persons assistance for transfer.

A staff member stated that the resident ambulated with two-person assistance side by side, and a second staff member stated that the resident ambulated with one person assistance from the bed to the bathroom.

A third staff member stated that the pictogram placed in the residents' room represent the method of transfer, not the resident's mobility.

As such, the resident was at risk of injury when the staff members were not using safe transferring techniques when assisting the resident.

Sources:

Residents' health care records and interviews with three staff members.

[211]

This order must be complied with by January 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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