

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

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

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 5, 2019	2019_763116_0006	017423-19	Complaint

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**Licensee/Titulaire de permis**

AXR Operating (National) LP, by its general partners  
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON  
L4W 0E4

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

Elginwood  
182 Yorkland Street RICHMOND HILL ON L4S 2M9

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

SARAN DANIEL-DODD (116), JACK SHI (760)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): November 12, 13, 14 and 15, 2019.**

**The following intake was completed in this inspection:  
Log # 017423-19 related to falls prevention**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Physiotherapists (PTs), Director of Care (DOC), and substitute decision maker (SDM) of resident #006.**

**During the course of the inspection, the inspectors conducted observations, record reviews and interviews.**

**The following Inspection Protocols were used during this inspection:  
Falls Prevention  
Minimizing of Restraining**

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

**3 WN(s)**

**3 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification                      VPC – Voluntary Plan of Correction                      DR – Director Referral                      CO – Compliance Order                      WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit                      VPC – Plan de redressement volontaire                      DR – Aiguillage au directeur                      CO – Ordre de conformité                      WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan of care for resident #006 provides clear directions to staff and others who provide direct care to the resident.

A complaint was submitted to the Ministry of Long Term Care (MLTC) regarding an incident involving resident #006 which resulted in an injury.

During the inspection, Inspector #760 observed resident #006 sitting in their wheelchair. The wheelchair was placed in a specified position.

A review of resident #006's current written plan of care indicated an intervention to place the wheelchair in a specified position.

An interview with PT #107, detailed that the written plan of care for resident #006 indicated that staff were required to receive consent from their SDM prior to being able to place the wheelchair in the specified position. In addition, PT #107 indicated that the nursing staff were to conduct a specific assessment, prior to being able to position the wheelchair in the required position, as per the directions in their written plan of care.

During an interview with DOC #103, it was confirmed that resident #006's written plan of care does not provide clear directions to direct care staff on when to initiate the identified function of resident #006's wheelchair. [s. 6. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**WN #2: 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 any policy or procedure that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

In accordance to O. Reg 79/10, r. 49 (1), the falls prevention and management program must, at a minimum, provide monitoring of residents and the use of equipment, supplies, devices and assistive aids.

A review of the home's policy titled "Safe Resident Handling" and the description of "No Manual Lift Directive, indicates the use of a specific equipment to transfer a resident after they have fallen.

A complaint was submitted to the Ministry of Long Term Care (MLTC) regarding an incident involving resident #006 which resulted in an injury.

A review of the progress notes indicated that resident #006 was found on the floor after the staff member that was transferring them independently left the room to get a lifting device.

Agency PSW #102 was interviewed and confirmed that the home has a no lift policy. They indicated that two staff members needed to be present to use a specific equipment to transfer the resident after being found in an identified position.

An interview was also conducted with PSW #106 who indicated they were unaware of the home's no lift policy at the time of resident #006's incident. PSW #106 indicated they were made aware of the policy following the incident and confirmed they should have

used the specified equipment to transfer resident #006.

An interview was conducted with RPN #100 who indicated they did not use the specified equipment to transfer resident #006 from the identified position. Three PSWs were present when they transferred resident #006 in an identified manner. RPN #100 indicated being aware of the home's no lift policy, which indicates that staff are not to transfer the resident in an identified manner after a specified incident. RPN #100 confirmed they did not follow the home's no lift policy when they transferred resident #006 in an identified manner.

An interview with DOC #103 confirmed that staff did not follow the home's no lift policy when the staff members transferred resident #006 after being found in an identified location.

The licensee failed to ensure that the home's policy titled "Safe Resident Handling" and the description of "No Manual Lift Directive", was complied with, by moving the resident without the use of a specific equipment following an identified incident. [s. 8. (1) (a), s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's "Safe Resident Handling" policy is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a Personal Assistive Service Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

In accordance with the definition identified in section 33 (2) of the Long-Term Care Homes Act, 2007, a "PASD" means personal assistance services device, being a device used to assist a person with a routine activity of living.

A complaint was submitted to the Ministry of Long Term Care (MLTC) regarding an incident involving resident #006 which resulted in an injury.

The home's policy titled, "Resident Safety" and the description of "LTC Personal Assistance Service Device (PASD)" indicates the following:

A Personal Assistance Service Device (PASD) is used to assist a resident with their routine activity of living (e.g. lap tray, reclining chair) and may be included and used as part of their plan of care when the following is met:

- the PASD has been approved by the Physician, RN, RPN, OT, or PT
- Informed consent for PASD has been obtained from the resident or SDM and will be documented in the resident progress notes.
- the PASD is not used to restrain a resident (i.e. for fall prevention).

A review of resident #006's health record, progress notes and written plan of care at the time of the incident did not indicate the usage of an identified PASD.

A specified document was reviewed and completed by RPN #100 indicating that resident #006's wheelchair had been placed in a specific position.

An identified document was reviewed which indicated that on an identified date a specified PASD was used by resident #006.

An interview with PT #107 indicated that the use of the specified equipment is considered a PASD. PT #107 indicated the home's process of authorizing the use of a PASD includes receiving consent from the SDM, conducting an assessment from the PT, indicating the use of it in a nursing care plan and if there were any specific information about the PASD, it would be added to a task for nursing staff.

An interview with DOC #103 also verified this information.

An interview with agency PSW #102 confirmed resident #006 was placed in an identified position prior to leaving them to prevent an incident from occurring.

An interview with DOC #103 confirmed that the home did not ensure that the use of an identified PASD to assist with resident #006's activity of daily living was included in the resident's plan of care. [s. 33. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.***

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Issued on this 12th day of December, 2019

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

**Original report signed by the inspector.**