



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection 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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2017	2017_449619_0018	006465-17	Critical Incident System

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE SUITE 800 LONDON ON N6A 1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST MISSISSAUGA ON L5K 2K7

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

SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 5 & 6, 2017.

The purpose of this inspection was to inspect upon complaint log #006465-17 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the resident.

During the course of the inspection, the inspector interviewed staff and residents, reviewed critical incident logs and clinical records, reviewed policies and procedures, and observed the provision of care.

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

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

2 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :



The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturers' instructions.

On an identified date in March 2017, resident #001 was assisted to the bathroom by PSW #105. A review of the resident's written plan of care last updated in March 2017, indicated that the resident required staff assistance for transfers, and employed the use of an assistive device. Interview with resident #001 indicated that when they sat on the assistive device they fell onto the floor. A review of the progress notes indicated that the resident was assessed by the home's staff before being sent via ambulance to the hospital for further assessment and treatment. The resident returned to the home on an identified date in March 2017, with multiple injuries. According to an interview with PSW #105, prior to transferring the resident they noticed that the resident's assistive device had been removed. PSW #105 stated that they did not re-install the assistive device correctly before assisting the resident to sit, followed by the resident falling onto the floor. Interview with RPN #104 indicated that when an assistive device requires installation that staff should refer to the maintenance department to ensure correct installation of the device and confirmed that this was not done. Interview with DOC confirmed that PSW #105 did not re-install the assistive device in accordance with the manufacturers' instructions and that resident #001 incurred injuries as a result of the assistive device not being installed as per manufacturers instructions.

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).



Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of an incident that caused injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition no later than one business day.

On an identified date in March 2017, resident #001 fell off an unsecured assistive device and incurred injuries for which they required transfer and treatment at hospital. A review of the resident's hospital records indicated that the resident suffered injuries to multiple areas of their body. A review of the critical incident report indicated that the incident occurred on an identified date in March 2017, and was first submitted to the Director on a second identified date in March 2017, two days after the incident with injury occurred. Interview with registered staff #103 indicated that registered staff do not submit critical incident reports to the Director and that this is a task completed by the Director of Care (DOC). Interview with DOC acknowledged that at the direction of the Administrator, that all critical incident reports are submitted by the DOC. The DOC confirmed that the critical incident report in relation to the incident with injury to resident #001 was not submitted within one business day, and exceeded the timeline for submission as per the legislation.

Issued on this 28th day of July, 2017

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

Original report signed by the inspector.



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**Ministère de la Santé et
des Soins de longue durée**

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SAMANTHA DIPIERO (619)

Inspection No. /

No de l'inspection : 2017_449619_0018

Log No. /

Registre no: 006465-17

Type of Inspection /

Genre

Critical Incident System

d'inspection:

Report Date(s) /

Date(s) du Rapport : Jul 27, 2017

Licensee /

Titulaire de permis : DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON,
N6A-1K7

LTC Home /

Foyer de SLD : ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST, MISSISSAUGA, ON,
L5K-2K7

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Mary Whalen

To DEVONSHIRE ERIN MILLS INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
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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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

Order # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The Licensee shall ensure that the staff install, use, and monitor all assistive devices including assistive devices used by resident #001, in accordance with the manufacturers' instructions. The licensee shall also ensure that all direct care providers are aware and receiving training related to how and when to contact maintenance for the installation of assistive devices.

Grounds / Motifs :



Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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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
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1. 1. Judgement Matrix

- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Isolated
- Compliance History: One or more related non-compliances in the last three years

2. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturers' instructions.

On an identified date in March 2017, resident #001 was assisted to the bathroom by PSW #105. A review of the resident's written plan of care last updated in March 2017, indicated that the resident required staff assistance for transfers, and employed the use of an assistive device. Interview with resident #001 indicated that when they sat on the assistive device they fell onto the floor. A review of the progress notes indicated that the resident was assessed by the home's staff before being sent via ambulance to the hospital for further assessment and treatment. The resident returned to the home on an identified date in March 2017, with multiple injuries. According to an interview with PSW #105, prior to transferring the resident they noticed that the resident's assistive device had been removed. PSW #105 stated that they did not re-install the assistive device correctly before assisting the resident to sit, followed by the resident falling onto the floor. Interview with RPN #104 indicated that when an assistive device requires installation that staff should refer to the maintenance department to ensure correct installation of the device and confirmed that this was not done. Interview with DOC confirmed that PSW #105 did not re-install the assistive device in accordance with the manufacturers' instructions and that resident #001 incurred injuries as a result of the assistive device not being installed as per manufacturers instructions.

(619)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017



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Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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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 or by fax upon:

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



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of July, 2017

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Samantha Dipiero

Service Area Office /

Bureau régional de services : Hamilton Service Area Office