Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2017	2017_593573_0021	022029-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 15, 18, 19, 20, 21 and 22, 2017.

The following Critical Incident Log #022029-17 was inspected related to an incident that caused an injury to a resident for which resident was transferred to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the acting Assistant Director of Care, the Support Services Manager, the Quality Risk Management Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, reviewed residents health record and home's internal investigation documentation. In addition the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Legendé 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 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 with resident #001's transfers.

On a specified date, a Critical Incident Report (CIR) was submitted to the Director, regarding a fall incident for which resident #001 was sent to the hospital and resulted in a

significant change in resident's health status.

Resident # 001's Fall Incident Report on a identified date, indicated that resident #001 fell out from the transfer lift and sustained injury.

Resident #001 was admitted to the home with multiple diagnosis. Inspector #573 reviewed resident #001's transfer assessment on a identified date indicated mechanical total lift with full sling and two staff member required. A review of the written plan of care in place at the time of incident for transfers indicated that the resident required a total lift with two staff members for transfers.

During an interview on September 21, 2017, PSW #100 indicated to the inspector that on a identified day and time, PSW #101 called her to resident #001's room to assist with resident's transfer from wheel chair to bed. PSW #100 indicated that PSW #101 had already applied the sling to the resident #001 and attached the sling loops to the lift. PSW #100 indicated that she observed resident #001 was not positioned properly in the sling and was leaning forward in the sling. PSW #100 brought to the PSW #101 attention regarding the resident's positioning in the sling. PSW #101 readjusted the sling and requested PSW #100 to transfer the resident. While transferring resident #001 to the bed, the resident fell out of the sling and sustained injury. PSW #100 indicated that after the resident's fall, she observed that the transfer sling's padded leg sections were not applied correctly to the resident.

On September 21, 2017, at the request of Inspector #573, the home's Quality Care and Risk Management (QCRM) Coordinator demonstrated the correct application of the sling to the lift that was used with resident #001. Further she explained the safety risks related to the improper application of the sling when not crossing the sling's padded leg sections to the lift.

On September 21, 2017, Inspector #573 spoke with the Home's DOC, who indicated that the home conducted an internal investigation related to the resident #001's fall incident. The DOC indicated that upon investigation, it was found out that on a identified day, PSW #101 did not follow the safe transfers protocol by improper application and placement of transfer sling while transferring resident #001 from wheelchair to bed. [s. 36

Additional Required Actions:

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

Issued on this 5th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANANDRAJ NATARAJAN (573)
Inspection No. / No de l'inspection :	2017_593573_0021
Log No. / No de registre :	022029-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 5, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE LAURIER MANOR 1715 MONTREAL ROAD, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummins

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

Order # / Ordre no : 001

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

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 shall prepare, submit and implement a plan for achieving Compliance with section 36, to ensure actions are taken to protect residents from injury during transfers. The plan must outline the immediate steps that will be taken to ensure resident safety with regards to lifts and transfers. This plan must include but not be limited to the provision of re-education to all nursing staff as it relates to safe transferring techniques as per the licensee's training on safe lift and transfer. This education must include demonstration with all lifts in use in the home and with all different styles of transfer slings in use in the home.

The plan must also outline how the licensee will ensure that there is ongoing monitoring of compliance, with the licensee's safe transfer policy, by way of periodic observation of PSWs' transfer techniques by Registered Nursing Staff on all shifts.

This plan must be submitted in writing to Anandraj (Andy) Natarajan #573 Long Term Care Home (LTCH) Inspector at 347 Preston St, 4th floor, Ottawa, ON, K1S 3J4 or by fax (613) 569-9670 on or before October 20, 2017. This plan must be fully implemented by January 05, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting with resident #001's transfers.

On a specified date, a Critical Incident Report (CIR) was submitted to the Director, regarding a fall incident for which resident #001 was sent to the hospital and resulted in a significant change in resident's health status.

Resident # 001's Fall Incident Report on a identified date, indicated that resident #001 fell out from the transfer lift and sustained injury.

Resident #001 was admitted to the home with multiple diagnosis. Inspector #573 reviewed resident #001's transfer assessment on a identified date which indicated mechanical total lift with full sling and two staff member required. A review of the written plan of care in place at the time of incident for transfers indicated that the resident required a total lift with two staff members for transfers.

During an interview on September 21, 2017, PSW #100 indicated to the inspector that on a identified day and time, PSW #101 called her to resident #001's room to assist with resident's transfer from wheel chair to bed. PSW #100 indicated that PSW #101 had already applied the sling to the resident #001 and attached the sling loops to the lift. PSW #100 indicated that she observed resident #001 was not positioned properly in the sling and was leaning forward in the sling. PSW #100 brought to the PSW #101 attention regarding the resident's positioning in the sling. PSW #101 readjusted the sling and requested PSW #100 to transfer the resident. While transferring resident #001 to the bed, the resident fell out of the sling and sustained injury. PSW #100 indicated that after the resident's fall, she observed that the transfer sling's padded leg sections were not applied correctly to the resident.

On September 21, 2017, at the request of Inspector #573, the home's Quality Care and Risk Management (QCRM) Coordinator demonstrated the correct application of the sling to the lift that was used with resident #001. Further she explained the safety risks related to the improper application of the sling when not crossing the sling's padded leg sections to the lift.

On September 21, 2017, Inspector #573 spoke with the Home's DOC, who indicated that the home conducted an internal investigation related to the resident #001's fall incident. The DOC indicated that upon investigation, it was found out that on a identified day, PSW #101 did not follow the safe transfers protocol by improper application and placement of transfer sling while transferring resident #001 from wheelchair to bed.

The licensee has a history of non-compliance related to section 36, Most recently, a Voluntary Plan of Corrective Action (VPC) was issued on April 07, 2017, as a result of inspection #2017_658178_0002. A Compliance Order was

issued based on the severity of actual harm to the Resident.
(573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 05, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

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

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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 5th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Anandraj Natarajan

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