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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

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5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 31, 2015	2015_252513_0018	022451-15	Complaint

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 ROUGE VALLEY
551 Conlins Road TORONTO ON M1B 5S1

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

JUDITH HART (513)

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): October 5, 6, and 7, 2015.

During the course of the inspection, the inspector(s) spoke with residents and one resident's power of attorney, personal support workers (PSW), registered nursing staff, and director of care (DOC).

During the course of the inspection the inspector observed resident care, reviewed resident health records, policies and procedures, and schedules.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The Home's Transfer Devices Policy #01-05 states a process is in place which ensures the safest transfer possible for residents and staff, and all staff will follow the procedures

for use of transfer device provided in the Safe Lifting With Care Program (TLR Manual). The Home's Mechanical Lifts Policy #01-02 states two trained staff are required at all times when performing a mechanical lift transfer.

A review of the Home's Mechanical Lifts and Transfers Technique education attendance list showed that staff #100 received this education on a specified date in 2015.

On a specified date and time in 2015, the progress notes revealed resident #001 was being transferred by mechanical lift by staff #100. During the transfer the resident slipped from the sling. An assessment in hospital revealed an identified injury.

The written plan of care identified when resident #001 was transferred, the resident required total assistance of two staff with a mechanical lift.

An interview with staff #100 confirmed following care on a specified date, staff #100 attempted, by his/her self, to transfer the resident unassisted using a mechanical lift and sling. Staff #100 reported the sling straps were not placed as per protocol and the resident slipped from the sling. Staff #100 confirmed when transferring resident #001, two staff were not in attendance and safe transferring techniques were not used for resident #001 during the transfer.

An interview with the Director of Care (DOC) confirmed safe transferring techniques were not used by staff #100 when transferring resident #001, and two staff were required to transfer the resident when using the mechanical lift.

The scope of the incident is limited to one resident. The severity is actual harm in which the resident sustained injury during transfer by one staff and the safety straps were not properly positioned at the time of transfer. The Compliance History Report showed a prior voluntary plan of correction had been issued. There was also an existing compliance order for the licensee to prepare, submit and implement a plan ensuring staff use safe transferring and positioning devices and/or techniques as appropriate, when assisting residents with transfers and positioning. It was to be complied with by a specified date. [s. 36.]

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. 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 is provided to the resident as specified in the plan.

On a specified date and time in 2015, the progress notes revealed resident #001 had fallen from the sling while being transferred by mechanical lift. An assessment in hospital revealed an identified injury.

The written plan of care identified when resident #001 was transferred, the resident required total assistance with a mechanical lift and sling, by two staff.

An interview with staff #100 confirmed following care on a specified date, staff #100 attempted, by his/her self, to transfer the resident by sling using a mechanical lift.

Staff #100 confirmed resident #001's written plan of care identified the resident was to be transferred by two persons when using a mechanical lift and the resident was transferred by only one staff.

The DOC confirmed resident #001's written plan of care identified the resident was to be transferred by two persons when using the mechanical lift and the written plan of care was not provided as specified in the plan. [s. 6. (7)]

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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 plan, policy, protocol, procedure strategy or system instituted or otherwise put in place is complied with.

The Home's Transfer Devices Policy #01-05 states a process is in place, which ensures the safest transfer possible for residents and staff, and all staff will follow the procedures for use of transfer device provided in the Safe Lifting With Care Program (TLR Manual). The Home's Mechanical Lifts Policy #01-02 states two trained staff are required at all times when performing a mechanical lift transfer.

On a specified date and time, the progress notes revealed resident #001 had fallen from the sling while being transferred by mechanical lift. An assessment in hospital revealed an identified injury.

The written plan of care identified when resident #001 was transferred, the resident required total assistance with a mechanical lift and sling, by two staff.

An interview with staff #100 confirmed following care on a specified date, staff #100, by his/her self, transferred the resident using a mechanical lift. Staff #100 reported that the sling straps were not placed as per protocol and the resident slipped from the sling. Staff #100 then transferred the resident to the wheelchair using the sling and mechanical lift, by his/her self. He/she confirmed two-person assistance was required when using a mechanical lift.

The DOC confirmed staff #100 transferred resident #001 using a mechanical lift by his/her self, whereas the policy for transferring residents by mechanical lift require two-person assist. The policy for transferring residents using a mechanical lift was not followed. [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 ensure that any plan, policy, protocol, procedure strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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

Issued on this 13th day of January, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JUDITH HART (513)
Inspection No. / No de l'inspection :	2015_252513_0018
Log No. / Registre no:	022451-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 31, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE ROUGE VALLEY 551 Conlins Road, TORONTO, ON, M1B-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Terry Pilgrim-Deane

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) (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 shall ensure that for resident #001 staff use safe transferring techniques for every transfer, which adheres to the licensee's transfer policy and resident #001's plan of care.

Grounds / Motifs :

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

The Home's Transfer Devices Policy #01-05 states a process is in place, which ensures the safest transfer possible for residents and staff, and all staff will follow the procedures for use of transfer device provided in the Safe Lifting With Care Program (TLR Manual). The Mechanical Lifts Policy #01-02 states two trained staff are required at all times when performing a mechanical lift transfer.

A review of the Mechanical Lifts and Transfers Technique education attendance list showed staff #100 received this education on a specified date.

On a specified date and time, the progress notes revealed resident #001 was being transferred by mechanical lift from the bed to the chair by staff #100. During the transfer, the resident slipped from the sling to the floor. An assessment in hospital revealed an identified injury.

The written plan of care on a specified date, identified that when resident #001 was transferred, the resident required total assistance of two staff with a mechanical lift.

An interview with staff #100 confirmed that following care on a specified date,

staff #100, by his/her self, transferred the resident unassisted, using a mechanical lift and sling. Staff #100 reported that the sling straps were not placed as per protocol and the resident slipped from the sling. Staff #100 confirmed when transferring resident #001, two staff were not in attendance and safe transferring techniques were not used for resident #001 during transfer.

An interview with the Director of Care (DOC) confirmed safe transferring techniques were not used by staff #100 when transferring resident #001 and two staff were required to transfer the resident when using the mechanical lift.

The scope of the incident is limited to one resident. The severity is actual harm in which the resident sustained injury during transfer by one staff and the safety straps were not properly positioned at the time of transfer. The Compliance History Report showed a prior voluntary plan of correction was issued on a specific date. There was an existing compliance order, for the licensee to prepare, submit and implement a plan ensuring staff use safe transferring and positioning devices and/or techniques as appropriate, when assisting residents with transfers and positioning, to be complied with by a specific date. (513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 11, 2016

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
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, 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.

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, 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 31st day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Judith Hart

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