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 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2018	2018_776613_0001	029671-18, 029673-18, 029674-18, 029677-18, 029679-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Van Daele
39 Van Daele Street SAULT STE. MARIE ON P6B 4V3

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

LISA MOORE (613)

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 15 - 19, 2018 and November 7 - 8, 2018.

The following complaints were inspected during this inspection:

One Complaint that was submitted to the Director regarding alleged physical abuse and concerns with the provisions of care;

One Compliant that was submitted to the Director regarding a resident fall resulting in an injury and transfer to hospital;

One Complaint that was submitted to the Director regarding denied admission to the home;

One Complaint that was submitted to the Director regarding a resident fall and concerns with the provisions of care;

One Complaint submitted to the Director regarding concerns of discharge and residents' bill of rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Medical Director, Physiotherapist, Admission Coordinator, Resident Assessment Instrument (RAI) Coordinator, Behavioural Supports Ontario (BSO) RPN, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigations, and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

5 WN(s)
3 VPC(s)
2 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	Légende 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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between among residents.

Inspector #613 reviewed a Complaint Report that was received by the Director, alleging abuse to resident #001 and concerns regarding the provision of care.

During an interview with the complainant they stated that resident #002 struck resident #001 while they were sitting in their mobility aid in a hallway, resulting in an injury to resident #001 and a transfer to the hospital in April 2018. The complainant voiced concern related to resident #002's responsive behaviours.

A review of resident #002's progress notes indicated that resident #002 had two other incidents of abuse involving other residents. The progress notes revealed that in March 2018, the resident had displayed responsive behaviours towards resident #006 and in April 2017 towards resident #007.

A review of resident #002's care plan, specifically related to Responsive Behaviours towards other residents identified that the resident's care plan did not indicate such

behaviours, nor did the care plan provide for any interventions. The care plan only identified behaviours and interventions for staff during care.

The Inspector reviewed the resident's "Responsive Behaviour's Debrief" form, completed in March 2018, for the abuse incident that had occurred on a specific date in March 2018, that indicated that resident #002's responsive behaviours were escalating and instances of a specific behaviour were increasing. A review of the resident's "Responsive Behaviour's Debrief" form for the abuse incident involving resident #001, that had occurred on a specific date in April 2018, and noted that the form was dated April 2018, but had not been completed.

A review of the home's policy titled, "Responsive Behaviours Huddle, RC-17-01-05" last revised February 2017, identified that each new or escalating episode of responsive behaviours would be reviewed using a "huddle" format and debrief looking for proactive steps that could be taken to minimize the risk of recurrence. A review of the home's policy titled, "Responsive Behaviours, RC 17-01-04" last revised February 2017, identified that the nurse would ensure that the care plan contained information related to each behaviour observed and include what the behaviour was and interventions to deal with the behaviour.

During an interview with PSW #103, they stated that resident #002 had specific behaviours towards other residents, but was unaware if they had abused other residents.

During an interview with RPN #102, they stated that at the time of the incident, resident #002 would display a specific responsive behaviour in other resident rooms and display a specific responsive behaviour if they asked them to leave. RPN #102 confirmed that the resident had altercations with two other residents, prior to the abuse incident with resident #001. RPN #102 reviewed resident #002's care plan and confirmed that the care plan, following these incidents, did not identify specific responsive behaviours with other residents nor interventions to implement when responsive behaviours towards other residents occurred.

During an interview with the Director of Care (DOC), they verified that resident #002's care plan did not identify specific responsive behaviours towards other residents; rather, it only identified responsive behaviours towards staff. They also verified that the resident's care plan did not contain interventions to prevent harmful situations. [s. 55. (a)]

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. 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 use safe transferring and positioning devices or techniques when assisting residents.

Inspector #613 reviewed a Complaint Report that was received by the Director, revealing that resident #001 had a fall resulting in an injury and transfer to hospital in July 2018. The complaint alleged that the fall was a result of improper transferring by a staff member.

During an interview with the complainant, they stated that resident #001 had returned from the hospital on a specific date in July 2018. The complainant further stated that on a specific morning in July 2018, a staff member brought resident #001 to a dining room for a meal in their mobility aid without applying a specific device. The complainant stated that the staff member portered resident #001 in their mobility aid in a specific manner, which got caught and resulted in resident #001 falling out of their mobility aid, causing an injury that required a transfer to the hospital.

A review of the Critical Incident (CI) report that the home submitted to the Director in July 2018, revealed that PSW #107 had assisted resident #001 out of their room while they were sitting in their mobility aid. The PSW turned the mobility aid to face forward and resident #001 fell out of their mobility aid onto the floor, resulting with an injury and transfer to the hospital. The CI report identified that a specific device was not applied to the mobility aid to ensure comfort or safety for resident #001.

A review of the progress notes identified that resident #001 had been previously admitted to the hospital in July 2018 and had returned to the home one day prior to this incident.

A review of the care plan did not identify that resident #001's care plan had been revised to meet their current needs post hospitalization. The care plan did not identify the use of the specific device when staff assisted with resident's mobility aid. It identified one staff to assist with mobility aid when needed.

A review of the home's policy titled, "Care Planning, RC-05-01-01" last revised April 2017, identified that the care plan would be reflective of the resident's goals and preferences through collaboration with the resident/SDM. As the resident's status changed, members of the interdisciplinary team were to update the plan of care so that at any point in time, the care plan continued to be reflective of the current needs and preference of the resident. Staff were to ensure the care plan was revised when appropriate to reflect the resident's current needs, based on evaluation of (a) progress towards goals (b) response to care and treatment; and (c) significant changes in the resident's status.

During an interview with PSW #107, they stated that they had not applied the specific device to the resident's mobility aid. PSW #107 informed the Inspector that staff was in a rush to bring all the residents to the dining room for their breakfast on a specific date in July 2018, and did not have time to allow resident #001 to self propel their mobility aid, as they were in a hurry.

During an interview with RN #104, they stated that resident #001 had specific device for their mobility aid, which were located in their closet. RN #107 confirmed that the specific device were not identified in resident #001's care plan.

During an interview with the Physiotherapist, they stated that staff should be applying the specific device to all resident's mobility aids when they assist them with mobility to ensure their safety and comfort, whether it was a short or long distance mobility assistance. The Physiotherapist stated that it was the protocol and expectation to put the specific device on a mobility aid when staff applied an external force and assisted a resident with their mobility.

During an interview with the Director of Care (DOC), they stated that they had reviewed the video surveillance from the day of the fall, which revealed that there were no specific devices applied to resident #001's mobility aid during mobility assistance by PSW #107. The DOC confirmed PSW #107 had used poor judgment and should have applied the specific device to the mobility aid for safety. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 was provided to the resident as specified in the plan.

Inspector #613 reviewed a Complaint Report that was received by the Director, alleging abuse to resident #001 and concerns regarding the provision of care.

During an interview with the complainant they stated that resident #002 struck resident #001 while they were sitting in their mobility aid in the hallway, resulting in an injury to resident #001 and a transfer to the hospital.

A review of the Critical Incident (CI) report that the home submitted to the Director in April 2018, revealed that resident #002 had been displaying a specific responsive behaviour in a dining room and was brought to their room. While resident #002 was in their room, they began to display physically responsive behaivours towards PSW #100. PSW #100 then left the resident's room and resident #002 followed them out of the room into the hallway, where resident #002 approached resident #001 who was self-propelling their mobility aid in the hallway and punched them, causing an injury.

A review of resident #002's progress notes revealed that the resident had been displaying physically responsive behaviours towards staff earlier in the day, attempting to hit out at staff. The progress notes identified that PSW #100 and PSW #103 were attempting to provide care to resident #002 and PSW #103 left the room during the care to perform another task.

A review of resident #002's care plan identified that two staff were required for all care, one staff to distract and one to provide care.

During an interview with PSW #103, they stated resident #002 displayed a specific responsive behaviour prior to bringing them to their room. PSW #103 stated they left the room to bring resident #001 to the dining room for a snack and did not return to resident #002's room to assist PSW #100 with care. They confirmed that resident #002's care plan stated two people to provide care.

During an interview with PSW #100 they stated they did not know why PSW #103 had left during providing care to resident #002. They stated that they were concerned as resident #002 was displaying a specific responsive behaviour and caused injury to them. PSW #100 stated, they left the room and resident #002 followed them into the hallway. PSW #100 stated that they observed resident #001 in the hallway, outside of the dining room area, self-propelling their mobility aid towards their room, but did not remove them.

During an interview with the DOC, they confirmed that PSW #100 and PSW #103 did not follow the residents care plan and two staff should have provided care to resident #002 as directed in the care 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 to 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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #613 reviewed a Complaint Report that was received by the Director, alleging abuse to resident #001 and concerns regarding the provision of care.

During an interview with the complainant they stated that resident #002 struck resident #001while they were sitting in their mobility aid in the hallway, resulting in an injury to resident #001.

Physical abuse is defined within Ontario Regulation 79/10, as (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident.

A review of Critical Incident (CI) report that the home submitted to the Director in April 2018, revealed that resident #002 approached resident #001, who was self-propelling their mobility aid in a hallway and caused injury to them.

A review of resident #001's progress notes revealed that on a specific date in April 2018, resident #001's substitute decision-maker requested that a Social Worker speak with resident #001 to provide extra support as this incident may trigger past experiences. The progress notes identified that a student social worker and a Behavioural Supports Ontario (BSO) worker had met with resident #001 on a specific morning in April 2018. The progress notes disclosed that resident #001 had voiced fear of further harm from resident #002. The progress notes also indicated that no further social work or counselling had been provided to resident #001.

A review of the home's policy titled, "Zero Tolerance of Resident abuse and Neglect:

Response and Reporting, RC-02-01-02" last revised April 2017, identified that all staff shall offer specialized supports to resident/families involved in the alleged incident (e.g., social work, counseling, victim's support services, regulatory health authority) and consult with the interdisciplinary team to develop strategies to provide immediate and long-term care to the resident.

During an interview with RN #104, they stated that it was normal procedure for staff to make a referral to a social worker or another resource to ensure that a resident received support following an abuse incident.

During an interview with the Assistant Director of Care (ADOC), who was in the role of Acting Director of Care at the time of the incident, they stated that the student social worker and BSO had visited resident #001, the day after the incident had occurred, but no further visits were documented. They stated that the LTC Home did not have a social worker. The ADOC confirmed that no other specialized services were contacted or offered to provide support to resident #001.

During an interview with the Director of Care (DOC), they stated that further specialized supports should have been offered to resident #001 to ensure more support following the incident. [s. 20. (1)]

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 written policy in place to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

Inspector #613 reviewed a Complaint Report that was received by the Director, alleging abuse to resident #001 and concerns regarding the provision of care.

During an interview with the complainant they stated that resident #002 struck resident #001 while they were sitting in their mobility aid in a hallway, resulting in an injury to resident #001 and transfer to the hospital.

A review of the CI report that the home submitted to the Director in April 2018 did not identify that police force had been notified of the incident abuse between resident #002 towards resident #001.

A review of resident #002 and resident #001's progress notes did not contain documentation to identify that the police force had been notified of the abuse incident.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02" last revised April 2017, identified that management would promptly and objectively report all incidents to the police if there was reason to believe a criminal code offence has been committed. The Director of Care or designate would notify police authorities, as per jurisdictional and legislative requirements.

During an interview with the Assistant Director of Care (ADOC), who was in the role of Acting Director of Care at the time of the incident, they confirmed that the CI report and progress notes did not identify that the police had been notified immediately of the abuse incident. [s. 98.]

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 the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence, to be implemented voluntarily.

Issued on this 15th day of November, 2018

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

Ministère 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) :	LISA MOORE (613)
Inspection No. / No de l'inspection :	2018_776613_0001
Log No. / No de registre :	029671-18, 029673-18, 029674-18, 029677-18, 029679-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 13, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Van Daele 39 Van Daele Street, SAULT STE. MARIE, ON, P6B-4V3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Deschene

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

Ministère 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

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. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee must be compliant with r. 55 (a) of the Long Term Care Homes Act.

Specifically the licensee must:

(a) ensure that when a resident is displaying responsive behaviours towards other residents, that their care plan is updated immediately, identifying procedures and interventions to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between among residents.

Inspector #613 reviewed a Complaint Report that was received by the Director, alleging abuse to resident #001 and concerns regarding the provision of care.

During an interview with the complainant they stated that resident #002 struck

resident #001 while they were sitting in their mobility aid in a hallway, resulting in an injury to resident #001 and a transfer to the hospital in April 2018. The complainant voiced concern related to resident #002's responsive behaviours.

A review of resident #002's progress notes indicated that resident #002 had two other incidents of abuse involving other residents. The progress notes revealed that in March 2018, the resident had displayed responsive behaviours towards resident #006 and in April 2017 towards resident #007.

A review of resident #002's care plan, specifically related to Responsive Behaviours towards other residents identified that the resident's care plan did not indicate such behaviours, nor did the care plan provide for any interventions. The care plan only identified behaviours and interventions for staff during care.

The Inspector reviewed the resident's "Responsive Behaviour's Debrief" form, completed in March 2018, for the abuse incident that had occurred on a specific date in March 2018, that indicated that resident #002's responsive behaviours were escalating and instances of a specific behaviour were increasing. A review of the resident's "Responsive Behaviour's Debrief" form for the abuse incident involving resident #001, that had occurred on a specific date in April 2018, and noted that the form was dated April 2018, but had not been completed.

A review of the home's policy titled, "Responsive Behaviours Huddle, RC-17-01-05" last revised February 2017, identified that each new or escalating episode of responsive behaviours would be reviewed using a "huddle" format and debrief looking for proactive steps that could be taken to minimize the risk of recurrence. A review of the home's policy titled, "Responsive Behaviours, RC 17-01-04" last revised February 2017, identified that the nurse would ensure that the care plan contained information related to each behaviour observed and include what the behaviour was and interventions to deal with the behaviour.

During an interview with PSW #103, they stated that resident #002 had specific behaviours towards other residents, but was unaware if they had abused other residents.

During an interview with RPN #102, they stated that at the time of the incident, resident #002 would display a specific behaviour in other resident rooms and

display a specific responsive behaviour if they asked them to leave. RPN #102 confirmed that the resident had altercations with two other residents, prior to the abuse incident with resident #001. RPN #102 reviewed resident #002's care plan and confirmed that the care plan, following these incidents, did not identify specific responsive behaviours with other residents nor interventions to implement when responsive behaviours towards other residents occurred.

During an interview with the Director of Care (DOC), they verified that resident #002's care plan did not identify specific responsive behaviours towards other residents; rather, it only identified responsive behaviours towards staff. They also verified that the resident's care plan did not contain interventions to prevent harmful situations.

Although, the home had no previous compliance history with this specific area of the legislation, the severity of this issue was determined to be a level 3, as there was actual harm to the residents. The scope of the issue was a level 2, as it related to three of the three residents reviewed. (613)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 002

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 must be complaint with r. 36 of the Long Term Care Homes Act.

Specifically, the licensee must:

a) ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

b) ensure that residents care plans are revised and updated post hospitalization and when a significant change in the resident's status occurs.

Grounds / Motifs :

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

Inspector #613 reviewed a Complaint Report that was received by the Director, revealing that resident #001 had a fall resulting in an injury and transfer to hospital in July 2018. The complaint alleged that the fall was a result of improper transferring by a staff member.

During an interview with the complainant, they stated that resident #001 had returned from the hospital on a specific date in July 2018. The complainant further stated that on a specific morning in July 2018, a staff member brought resident #001 to a dining room for a meal in their mobility aid without applying a specific device. The complainant stated that the staff member portered resident #001 in their mobility aid in a specific manner, which got caught and resulted in resident #001 falling out of their mobility aid, causing an injury that required a transfer to the hospital.

A review of the Critical Incident (CI) report that the home submitted to the Director in July 2018, revealed that PSW #107 had assisted resident #001 out of their room while they were sitting in their mobility aid. The PSW turned the mobility aid to face forward and resident #001 fell out of their mobility aid onto the floor, resulting with an injury and transfer to the hospital. The CI report identified that a specific device was not applied to the mobility aid to ensure comfort or safety for resident #001.

A review of the progress notes identified that resident #001 had been previously admitted to the hospital in July 2018 and had returned to the home one day prior to this incident.

A review of the care plan did not identify that resident #001's care plan had been revised to meet their current needs post hospitalization. The care plan did not identify the use of the specific device when staff assisted with resident's mobility aid. It identified one staff to assist with mobility aid when needed.

A review of the home's policy titled, "Care Planning, RC-05-01-01" last revised April 2017, identified that the care plan would be reflective of the resident's goals and preferences through collaboration with the resident/SDM. As the resident's status changed, members of the interdisciplinary team were to update the plan of care so that at any point in time, the care plan continued to be reflective of the current needs and preference of the resident. Staff were to ensure the care plan was revised when appropriate to reflect the resident's current needs, based on evaluation of (a) progress towards goals (b) response to care and treatment; and (c) significant changes in the resident's status.

During an interview with PSW #107, they stated that they had not applied the specific device to the resident's mobility aid. PSW #107 informed the Inspector that staff was in a rush to bring all the residents to the dining room for their breakfast on a specific date in July 2018, and did not have time to allow resident #001 to self propel their mobility aid, as they were in a hurry.

During an interview with RN #104, they stated that resident #001 had specific device for their mobility aid, which were located in their closet. RN #107 confirmed that the specific device were not identified in resident #001's care

plan.

During an interview with the Physiotherapist, they stated that staff should be applying the specific device to all resident's mobility aids when they assist them with mobility to ensure their safety and comfort, whether it was a short or long distance mobility assistance. The Physiotherapist stated that it was the protocol and expectation to put the specific device on a mobility aid when staff applied an external force and assisted a resident with their mobility.

During an interview with the Director of Care (DOC), they stated that they had reviewed the video surveillance from the day of the fall, which revealed that there were no specific devices applied to resident #001's mobility aid during mobility assistance by PSW #107. The DOC confirmed PSW #107 had used poor judgment and should have applied the specific device to the mobility aid for safety.

Although the home had no previous compliance history for this specific legislation, the severity of this issue was determined to be a level 3, as there was actual harm to the residents. The scope of this issue was a level 1, as it related to one of the residents reviewed. (613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 13th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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