Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 9, 2023	
Inspection Number: 2023-1134-0002	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Fosterbrooke, Newcastle	
Lead Inspector Sheri Williams (741748)	**Inspector Digital Signature** Sheri A Williams Digitally signed by Sheri A Williams Date: 2023.06.14 11:45:51 -04'00'
Additional Inspector(s) Holly Wilson (741755) Sarah Gillis (623) was present during the inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15 - 19, 2023

The following intake(s) were inspected:
A critical incident related to a failure/breakdown of equipment resulting in resident injury.
A critical incident related to an improper transfer of resident incident resulting in injury.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1)

The licensee failed to ensure that all doors leading to stairways were kept closed, locked and equipped with a door access control system.

Rationale and Summary

An open staircase with three stairs was observed in the basement of the long-term care home (LTCH) at the end of a hallway leading up to an exit and open stairwell. The door to the hallway was observed to be open and unlocked, and there was no door access control panel to restrict resident access. The elevator to the basement area did not have an access code to restrict access, as residents attend the basement area for meal services, the harvest room and the hair salon.

The homes policy titled LTC-Door Safety states “All doors leading to stairways and the outside of the Home must be kept closed and locked and equipped with a door access control system that is kept on at all times.”

Environmental Services Manager (ESM) indicated they did not believe the doors could be locked. The Executive Director (ED) confirmed the door leading to the stairs is not always closed, and there is no lock or door access control system in place to restrict access to that area. The ED indicated the homes policy is that door should be coded and locked.

Failing to ensure that doors leading to stairs are closed and locked poses a risk of residents accessing them and being injured.

Sources:
Observations, Policy Resident Safety/LTC-Door Safety. Interviews with ESM and ED. [741748]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that doors leading to non-resident areas were kept closed and locked to prevent unrestricted access to residents.

Rationale and Summary

On three consecutive days during the inspection the home's dry food storage room in the basement was observed open and unlocked with no staff in the vicinity to supervise it. The doors to the hallway leading to the storage room do not have a lock or door access control system to restrict residents. The elevator to the basement does not restrict any residents from accessing the basement.

The home's policy titled Resident Safety-LTC Door Safety states "All doors leading to non-residential areas (e.g., kitchen and laundry) must be kept closed and equipped with locks to restrict unsupervised access to those areas by residents."

ESM, two staff and the ED each, during separate interviews, indicated that the dry storage room was not a resident space and the doors to the dry storage area should be locked when unattended.

Failing to ensure doors leading to non-resident areas are kept closed and locks posed a safety risk to residents.

Sources:
Observations, Policy-Resident Safety-LTC-Door Safety, Interviews with ESM, staff, and ED. [741748]

WRITTEN NOTIFICATION: Maintenance Services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

The licensee has failed to ensure that procedures are developed and implemented to ensure that, (a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

Rationale and Summary:

A Critical Incident Report (CIR) was received by the Director regarding a failure/breakdown of equipment which indicated a resident sustained a fall to the floor during the transfer utilizing the Maximove lift and sling supplied by Arjo Canada Inc.

Arjo Canada Inc.'s Preventative Maintenance Schedule provides guidance for the daily pre start-up, weekly, monthly and yearly schedule to ensure that the basic steps are reviewed to maintain product safety for the residents.

Record review of the daily pre-start and monthly check list does not include all the required steps identified in the manufactures specifications, to ensure the Maximove lift is safe for use. There was no evidence of a weekly checklist.

An interview with the ESM indicated that in 2022 and 2023, preventative maintenance (PM) was done on the Maximove lift by the Arjo Canada Inc. service technician. The ESM was not aware that written documentation was required to be kept in 2022. For 2023, the ESM indicated that written documentation was kept, however, the PM Maximove Checklist did not include all the main recommended items identified on the Arjo PM manual for startup, weekly and monthly checklist.

An interview with the ED confirmed that the expectation is that the home complete and keep records of any PM done in the home. The PM and the pre-startup, weekly and monthly checklist must be done in accordance with the manufacturer, Arjo Canada Inc.'s scheduled PM

for the Maximove lift.

Failure to ensure that preventative maintenance of mechanical lifts was completed in accordance with the manufacturer's instructions puts residents at risk of injury.

Sources:
Clinical health record, the homes daily pre-start-up and monthly Maximove Checklist, Arjo Canada Maximove PM manual, Interviews with ESM, Arjo representative, and ED.
[741755]

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATION UNDER S. 27 OF ACT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. iii.

The Licensee failed to ensure that when making a report to the Director under section 27 (2) of the Act, the licensee shall include the names of staff members who responded or are responding to the incident.

Rationale and Summary

A CIR was submitted to the Director that did not include the name of the staff who was involved in the alleged abuse incident of a resident.

The ED stated they knew that the names of any staff members who were involved in the critical incident were required to be submitted in writing to the Director and could not say why they were not.

Failing to include staff names in a CIR submitted to the Director did not allow for transparency or accurate reporting.

Sources:
CIR, Interview with ED
[741748]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Provide access to the electronic health record including access to the resident's plan of care to all direct care staff, including agency staff, prior to them providing any care.
2. Develop a process in writing to ensure that any new staff including Agency, who will be providing direct resident care, have immediate and convenient access to the plan of care including electronic records. Keep a documented record of this process and make it available to the inspector upon request.

Grounds

The Licensee failed to ensure that staff and others who provided direct care to a resident was kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Rationale and Summary

A CIR was submitted to the Director related to improper care of a resident resulting in a fracture injury.

The ED indicated that an agency staff member identified in the incident did not have immediate or convenient access to the resident plan of care, and that they did not provide the level of assistance required to the resident resulting in the resident falling and having a fracture injury.

An RPN indicated the resident plan of care is only available in the electronic health record, and that the agency staff member involved in the incident, would have to ask Registered Staff for access. The ADOC indicated that it is the homes expectation that staff would provide

assistance according to the resident's plan of care, and agency staff would have to seek the assistance of a fellow staff member to access it. The ED confirmed the home's policy is that staff assist residents according to the resident plan of care and in order for the agency staff involved in the incident to have accessed the resident plan of care they would have had to ask a co-worker to look it up for them.

Failing to ensure agency staff had access to the resident's plan of care resulted in the agency staff being unaware of the resident's care needs and an unsafe transfer with injury to the resident.

This order must be complied with by
August 9, 2023

Sources:
CIR, licensee's internal investigation, resident clinical health record, interviews with staff, ADOC and ED.
[741748]

COMPLIANCE ORDER CO #002 TRANSFERING AND POSITIONING TECHNIQUES

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
1. Educate the specific PSW staff identified in the incident on transferring techniques for the involved resident.
2. Educate all agency staff working in the home over a four-week period on how to access the resident plan of care in the electronic health care record, specifically transferring and lifting requirements.
3. Keep a documented record of education, including time and date, who attended, who instructed and details of the content that was instructed. Make this available to the inspector

upon request.

Grounds

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

Rationale and Summary:

A CIR was received by the Director regarding a failure/breakdown of equipment which indicated a resident sustained a fall to the floor during the transfer utilizing the Maximove lift, and sling supplied by Arjo Canada Inc. The CIR indicated the resident was sitting in the sling, and secured to the lift, during the lift/transfer/repositioning steps, the sling became unclipped, and the resident sustained a fall.

The licensees Safe Lift and Transfer checklist identifies the required lift/transfer/reposition steps that two staff were to take when lifting a resident from a chair to the bed while using a mechanical lift. Specifically, when the resident is securely attached to the lift, the resident is raised up using the mechanical device controls, high enough for the resident to clear the chair and the bed. The staff driving the lift, positions the lift holding the resident, directly above the bed. The other PSW should position themselves beside the bed to assist in guiding the resident to the correct sitting position. Pulling the resident is not required if the lift is positioned correctly.

The procedures provided by the manufacturer, Arjo Canada Inc., identify the Instruction for Use of the Maxi Move has the following warnings:

1. Do not attempt to move the lift by pulling or pushing on the patient as this can cause the lift to topple over and cause injuries. Always use the maneuvering handle when displacing the lift.

2. Always check that all the sling clip attachments are fully in position before and during the lifting cycle and in tension as the patient’s weight is gradually taken up.

The Health Canada Mandatory Medical Device Problem Reporting Form reported by Arjo Canada Inc., the supplier of the lift and sling for the resident confirmed that only a force in the

opposite direction greater than the one applied by the gravity of the person's weight would be required to pull out a clip under tension. It is possible that the staff who lifted the patient's legs would have generated this force required to detach the clip.

Review of written statements and interview with the staff indicated in the incident confirmed that the resident legs and feet were held by the staff while they pulled the resident by the feet, over and on top of the bed. An audible click was heard by the staff, indicating one of the leg clips had disconnected from the lift and the resident slid out of the sling and down to the floor.

An interview with the ED confirmed that the resident was not transferred according to the safe lift and transfer checklist, and Arjo Canada Inc's guidelines for the Maximove lift were not followed.

Failure to correctly use safe transferring and positioning techniques resulted in a resident falling from the lift.

Sources:
CIR, Arjo Canada Inc Maximove User Manual, Health Canada Mandatory Medical Device Problem Reporting Form, Internal Investigation, Safe lift and Transfer Checklist, Interviews with staff and ED.
[741755]

2.The licensee failed to ensure that when staff transferred a resident, they used safe transferring and positioning techniques.

Rationale and Summary

A CIR was submitted to the director for improper care and treatment related to an improper transfer of a resident resulting in a fracture injury.

The resident’s written plan of care indicated the resident require extensive assistance of two staff using a sit /stand lift for transfers.

The internal investigation notes indicated that an RPN responded to the incident and an agency staff told them that a resident asked staff to assist them to the bathroom. The agency staff

reported that, and they asked the resident if they could walk, and they said yes. The agency staff assisted the resident to ambulate to the washroom. While ambulating, the resident lost their balance and fell sustaining a fracture.

The ED indicated that the agency staff did not read the transfer logo and that they did not have access to resident's written plan of care in the electronic records.

Failing to ensure that staff used safe transfer techniques resulted in significant injury to the resident.

This order must be complied with by
August 9, 2023

Sources:
CIR, licensee's internal investigation, resident clinical records, Policy-Operation of Mechanical Lifting/Transferring and Repositioning Devices, interviews with staff and ED.
[741748]

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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