Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 3, 2020	2019_817652_0029	019293-19, 019500-19, 020215-19, 020530-19, 022696-19	Critical Incident System

Licensee/Titulaire de permis

Harold and Grace Baker Centre
1 Northwestern Avenue TORONTO ON M6M 2J7

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

Harold and Grace Baker Centre
1 Northwestern Avenue TORONTO ON M6M 2J7

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

NATALIE MOLIN (652), CECILIA FULTON (618)

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): November 26, 28, and December 4, 5, 6, 2019.

The following critical incident system (CIS) inspection was conducted:

Log: #019293-19 related to the Prevention of Abuse and Neglect
Log: #019500-19 related to the Prevention of Abuse and Neglect
Log: # 020215-19 related to Falls Prevention
Log: #020530-19 related to Falls Prevention
Log: #022696-19 related to Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), registered nursing staff, personal support workers (PSWs) and substitute decision maker (SDM)

During the course of the inspection, the inspector(s) conducted a tour of the home; observed staff to resident interactions and the provision of care, reviewed the home's investigations and conducted records review.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects and that their dignity had been fully respected and promoted.

This inspection was initiated to inspect a Critical Incident System (CIS) Report submitted by the home to the Ministry of Long Term Care (MLTC) related to an alleged abuse of resident #005 that occurred on an identified date.

Inspector #618 reviewed the video provided to the Licensee by resident #005's family. There were two videos. One of the videos that did not show the resident, contained audio of staff speaking to each other and to the resident. The audio did not contain anything that would be considered abuse.

Inspector #618 reviewed the video that showed the resident sitting. PSW #103 was heard speaking about what the resident was wearing and was seen grabbing the resident ’s garment in a rough manner. The resident did not have any reaction to this action.

In an Interview PSW #103 identified that they saw the resident wearing an identified garment, and wanted to point out to the staff looking after the resident that the garment needed to be changed. PSW #103 identified that the action of grabbing the resident’s garment in the manner they had, and carrying on a conversation like the one they had in the presence of the resident was not proper or dignified.

2. Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) Report on an identified date, related to staff to resident abuse. This CIS indicated the family member of resident #001 informed the licensee that they were concerned about abuse of resident #001, and provided the home videos.

The first video showed PSW #100 immediately lowered the head of resident #001's bed to the lowest position after their meal.

The second video showed PSW #100 and PSW #109 providing care to resident #001 in a hurried an undignified manner. Later in the video, PSW #109 was seen to leave the room, and PSW #100 performed a mechanical transfer by themselves with the resident in it.

The third video showed PSW #100 providing care to resident #001 in a hurried manner.

Record review of resident #001's written plan of care on an identified date, indicated resident #001 had an identified deficit and staff to explain the procedures before starting care. This plan of care also indicated resident #001 required verbal identification of staff by name and role upon approach.

In an interview PSW #100 viewed the three videos as mentioned above and acknowledged that resident #001 was not treated with dignity and respect.

In an interview PSW #109 indicated they could not recall the incident.

In an interview the director of care (DOC) confirmed PSW #100 and PSW #109 did not treat resident #001 with dignity and respect upon review of the three videos.

There was evidence in the videos to support that PSW #100 and PSW #109 did not treat resident #001 with dignity and respect during care, related to the fact that they did not communicate to resident #001 the care they were providing. Care was performed in a hurried and undignified manner and resident #001 was not provided privacy during care.

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 was provided to the resident as specified in the plan.

This inspection was initiated to inspect a CIS submitted to the MLTC by the licensee

related to a fall incurred by resident #004 on an identified date.

Review of resident #004's written plan of care identified the level of support the resident required due to healthcare deficits.

The Licensee's investigation of this incident included an interview with PSW #105 who provided the identified care to resident #004. PSW #105 confirmed in that interview that they had not provided the identified resident care as identified in the written plan of care.

PSW #105 was not available for interview during this inspection.

Interview with the ED confirmed the above noted investigation and confirmed that care was not provided to resident #004 as specified in the plan.

2. This inspection was initiated to inspect a CIS report submitted to the MLTC by the licensee related to a fall incurred by resident #003 on an identified date.

Review of resident #003's written plan of care identified the interventions required to perform the identified care.

The Licensee's investigation of this incident included an interview with PSW #104 who provided the care to resident #003. PSW #104, stated in that interview that they had provided the resident’s care by themselves, as they always do, and that they had forgotten to put the resident’s side rail up before carrying out the task for the resident.

PSW #104 was not available for interview.

Interview with the Administrator confirmed the above noted investigation and confirmed that care was not provided to resident #003 as specified in the plan.

3. MLTC received a Critical Incident System (CIS) Report on an identified date, related to staff to resident abuse. This CIS indicated the family member of resident #001 informed the licensee that they were concerned about abuse of resident #001, and provided the home videos.

Video one showed PSW #100 feeding resident #001 without positioning the resident as indicated in the resident's written plan of care. After feeding the resident, PSW #100

failed to maintain resident #001 in the position identified in the written plan of care.

Review of resident #001's written plan of care on an identified date, indicated staff to position resident #001 at 90 degrees angle for feeding and ensure they remained up for 30 minutes after meals.

In an Interview PSW #109 indicated they had access to resident #001's written plan of care in Point of Care (POC) and should be aware of the interventions for feeding resident #001, however they did not look at it and was not aware of the interventions or resident #001's risk for choking.

Interview with the DOC verified that PSW #100 did not follow resident #001's plan of care.

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 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 residents.

Review of a video taken on an identified date and time, showed PSW #100 performing identified resident care in a manner that was contrary to the resident's written plan of care.

Resident #001's written plan of care clearly identified the level of support they required for the safe provision of the identified care. Video review and interview with PSW #100 confirmed that the care had not been provided using the identified interventions.

Record review of resident #001's written plan of care on an identified date, indicated resident #001 required support for the identified task due to healthcare deficits.This written plan of care also indicated resident #001 was not able to assist with the task at all, and required two staff full support for the task to be carried out safely.

In an interview PSW #100 acknowledged PSW #109 left during the task, did not return, and they performed the identified task for resident #001 on their own. PSW #100 also acknowledged upon review of the video recording that they carried out the task for resident #001 unsafely.

In an interview the DOC verified that PSW #100 did not perform the task safely for resident #001, and there should be two people always to safely carry out the task.

As a result of non-compliance identified for resident #001 the resident sample was expanded to three.

Non compliance with r. 36 was identified for resident #003, and resident #004.

Record review and staff interviews identified that on an identified date, PSW #104,performed an identified task for resident #003 in an unsafe manner, which resulted in injury to resident #003.

Review of the written plan of care identified the interventions required for the identified care.

The Licensee's investigation of this incident included an interview with PSW #104 who provided the care to resident #003. PSW #104, stated in that interview that they had not followed the interventions included in the residents written plan of care when performing the identified care.

Record review and staff interviews identified that on an identified date, PSW #105, performed unsafe transferring of resident #004, which resulted in injury to resident #004.

Review of the written plan of care identified the interventions required for the identified care.

The Licensee's investigation of this incident included an interview with PSW #105 who

provided the care to resident #004. PSW #105 stated in the interview that they had not followed the interventions included in the resident's written plan of care when performing this resident transfer.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Under O. Reg. 79/10, s.2 (1) for the purpose of the definition "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of “physical abuse” in subsection 2 (1) of the Act, “physical abuse” means
c) the use of physical force by a resident that causes physical injury to another resident;

MLTC received a CIS report submitted by the home related to staff abuse of resident #002 on an identified date. This CIS indicated the ED had reviewed a video to see if staff were following a new process, for an identified service. On the video, the ED observed, PSW #110 struck resident #002 on an identified body part then removing them from an identified location. No other staff members witnessed the events as seen by the video. Resident #002 was assessed by the home and sustained no injury. Social Worker met with resident #002 to provide emotional support; resident did not recall the incident.

Review of the video provided to inspector #652 by the home confirmed the information provided above in the CIS report.

In an interview resident #002 could not recall the incident.

In an interview, PSW #110 verified that they struck resident #002 on the identified body part because they were attempting to take the co-resident's item. PSW #110 acknowledged that they had received training on the prevention of abuse and neglect and was aware their actions constituted abuse.

In an interview, DOC verified that the home's investigations substantiated physical abuse to resident #002 by PSW #110 and they received disciplinary actions.

There is evidence in the video to support the definitions of emotional abuse and physical abuse.

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 residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MOLIN (652), CECILIA FULTON (618)
Inspection No. / No de l'inspection :	2019_817652_0029
Log No. / No de registre :	019293-19, 019500-19, 020215-19, 020530-19, 022696-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 3, 2020
Licensee / Titulaire de permis :	Harold and Grace Baker Centre 1 Northwestern Avenue, TORONTO, ON, M6M-2J7
LTC Home / Foyer de SLD :	Harold and Grace Baker Centre 1 Northwestern Avenue, TORONTO, ON, M6M-2J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Langton

To Harold and Grace Baker Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The Licensee must be compliant with LTCHA, 2007, s. 3. (1) 1

Specifically, the Licensee shall ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity had been fully respected and promoted.

The Licensee is to:

1) Develop and deliver an education program for direct care staff, PSWs, and registered staff.

Education is to include, but not be limited to:
-A review of the homes policy on the Residents' Bill of Rights
- The roles and responsibilities of staff to incorporate the Resident's Bill of Right into their practice.

2) Conduct post-training evaluation to ensure comprehension of the education and maintain evaluation records.

Grounds / Motifs :

1. The Licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects and that their dignity had been fully respected and promoted.

This inspection was initiated to inspect a Critical Incident System (CIS) Report submitted by the home to the Ministry of Long Term Care (MLTC) related to an alleged abuse of resident #005 that occurred on an identified date.

Inspector #618 reviewed the video provided to the Licensee by resident #005's family. There were two videos. One of the videos that did not show the resident, contained audio of staff speaking to each other and to the resident. The audio did not contain anything that would be considered abuse.

Inspector #618 reviewed the video that showed the resident sitting. PSW #103 was heard speaking about what the resident was wearing and was seen grabbing the resident's garment in a rough manner. The resident did not have any reaction to this action.

In an Interview PSW #103 identified that they saw the resident wearing an identified garment, and wanted to point out to the staff looking after the resident that the garment needed to be changed. PSW #103 identified that the action of grabbing the resident's garment in the manner they had, and carrying on a conversation like the one they had in the presence of the resident was not proper or dignified.
(618)

2. Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) Report on an identified date, related to staff to resident abuse. This CIS indicated the family member of resident #001 informed the licensee that they were concerned about abuse of resident #001, and provided the home videos.

The first video showed PSW #100 immediately lowered the head of resident #001's bed to the lowest position after their meal.

The second video showed PSW #100 and PSW #109 providing care to resident #001 in a hurried an undignified manner. Later in the video, PSW #109 was seen to leave the room, and PSW #100 performed a mechanical transfer by

themselves with the resident in it.

The third video showed PSW #100 providing care to resident #001 in a hurried manner.

Record review of resident #001's written plan of care on an identified date, indicated resident #001 had an identified deficit and staff to explain the procedures before starting care. This plan of care also indicated resident #001 required verbal identification of staff by name and role upon approach.

In an interview PSW #100 viewed the three videos as mentioned above and acknowledged that resident #001 was not treated with dignity and respect.

In an interview PSW #109 indicated they could not recall the incident.

In an interview the director of care (DOC) confirmed PSW #100 and PSW #109 did not treat resident #001 with dignity and respect upon review of the three videos.

There was evidence in the videos to support that PSW #100 and PSW #109 did not treat resident #001 with dignity and respect during care, related to the fact that they did not communicate to resident #001 the care they were providing. Care was performed in a hurried and undignified manner and resident #001 was not provided privacy during care.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history as they had previous non-compliance to the same subsection of the LTCHA, 2007, s. 3. (1) 1 that included:
1) VPC issued September 6, 2018 (2018_484646_0009). (652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The Licensee must be compliant with LTCHA, 2007 s. 6. (7)

Specifically, the Licensee shall ensure that care set out in the plan of care is provided to residents #001, #003 and #004 and all other residents as specified in the plan.

The Licensee is to:

1) Develop and deliver an education program for direct care staff, PSWs, and registered staff.

Education is to include, but not be limited to:
- review of how to access residents' plan of care.
- staff roles and responsibilities to be knowledgeable of the plan of care.

Conduct post-training evaluation to ensure comprehension of the education and maintain evaluation records.

Grounds / Motifs :

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.

This inspection was initiated to inspect a CIS submitted to the MLTC by the licensee related to a fall incurred by resident #004 on an identified date.

Review of resident #004's written plan of care identified the level of support the resident required due to healthcare deficits.

The Licensee's investigation of this incident included an interview with PSW #105 who provided the identified care to resident #004. PSW #105 confirmed in that interview that they had not provided the identified resident care as identified in the written plan of care.

PSW #105 was not available for interview during this inspection.

Interview with the ED confirmed the above noted investigation and confirmed that care was not provided to resident #004 as specified in the plan. (618)

2. This inspection was initiated to inspect a CIS report submitted to the MLTC by the licensee related to a fall incurred by resident #003 on an identified date.

Review of resident #003's written plan of care identified the interventions required to perform the identified care.

The Licensee's investigation of this incident included an interview with PSW #104 who provided the care to resident #003. PSW #104, stated in that interview that they had provided the resident's care by themselves, as they always do, and that they had forgotten to put the resident's side rail up before carrying out the task for the resident.

PSW #104 was not available for interview.

Interview with the Administrator confirmed the above noted investigation and confirmed that care was not provided to resident #003 as specified in the plan. (618)

3. MLTC received a Critical Incident System (CIS) Report on an identified date, related to staff to resident abuse. This CIS indicated the family member of resident #001 informed the licensee that they were concerned about abuse of resident #001, and provided the home videos.

Video one showed PSW #100 feeding resident #001 without positioning the resident as indicated in the resident's written plan of care. After feeding the resident, PSW #100 failed to maintain resident #001 in the position identified in

the written plan of care.

Review of resident #001's written plan of care on an identified date, indicated staff to position resident #001 at 90 degrees angle for feeding and ensure they remained up for 30 minutes after meals.

In an Interview PSW #109 indicated they had access to resident #001's written plan of care in Point of Care (POC) and should be aware of the interventions for feeding resident #001, however they did not look at it and was not aware of the interventions or resident #001's risk for choking.

Interview with the DOC verified that PSW #100 did not follow resident #001's plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to resident. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history as they had previous non-compliance to the same subsection of the LTCHA, 2007 s. 6. (7) that included:
1)VPC issued September 6, 2018 (2018_484646_0009). (652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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 compliant with LTCHA, 2007, r. 36.

Specifically, the Licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1) Develop and deliver an education program for direct care staff, PSWs and registered staff.

Education is to include, but not be limited to:
-A review of the home's policy on safe transferring and positioning techniques with a focus on expectations when two person care is indicated.

2) Conduct post-training evaluation to ensure comprehension of bed mobility, as it relates to assisting a resident with hygiene while in bed. Maintain evaluation records.

3) Audit PSW staff members to ensure they are using safe transfer and positioning techniques for resident #001and #004 and all other residents who require transfer and positioning.

Audits should include date, unit, person conducting the audit, staff being audited, concerns identified, and actions taken to address identified concerns. Records should be maintained for review.

Grounds / Motifs :

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

Review of a video taken on an identified date and time, showed PSW #100 performing identified resident care in a manner that was contrary to the resident's written plan of care.

Resident #001's written plan of care clearly identified the level of support they required for the safe provision of the identified care. Video review and interview with PSW #100 confirmed that the care had not been provided using the identified interventions.

Record review of resident #001's written plan of care on an identified date, indicated resident #001 required support for the identified task due to healthcare deficits.This written plan of care also indicated resident #001 was not able to assist with the task at all, and required two staff full support for the task to be carried out safely.

In an interview PSW #100 acknowledged PSW #109 left during the task, did not return, and they performed the identified task for resident #001 on their own. PSW #100 also acknowledged upon review of the video recording that they carried out the task for resident #001 unsafely.

In an interview the DOC verified that PSW #100 did not perform the task safely for resident #001, and there should be two people always to safely carry out the task.

As a result of non-compliance identified for resident #001 the resident sample was expanded to three.

Non compliance with r. 36 was identified for resident #003, and resident #004.

Record review and staff interviews identified that on an identified date, PSW #104,performed an identified task for resident #003 in an unsafe manner, which resulted in injury to resident #003.

Review of the written plan of care identified the interventions required for the identified care.

The Licensee's investigation of this incident included an interview with PSW #104 who provided the care to resident #003. PSW #104, stated in that interview that they had not followed the interventions included in the residents written plan of care when performing the identified care.

Record review and staff interviews identified that on an identified date, PSW #105, performed unsafe transferring of resident #004, which resulted in injury to resident #004.

Review of the written plan of care identified the interventions required for the identified care.

The Licensee's investigation of this incident included an interview with PSW #105 who provided the care to resident #004. PSW #105 stated in the interview that they had not followed the interventions included in the resident's written plan of care when performing this resident transfer.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 3 as it was widespread. The home had a level 3.history as they had previous non-compliance to the same subsection of the O. Reg. 79/10 that included:
1)WN issued July 04, 2019 (2019_642698_0009).
(652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2020

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 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:

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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 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 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 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 3rd day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Molin

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