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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 3, 2023	
Inspection Number: 2023-1317-0003	
Inspection Type: Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Harmony Hills Community, Toronto	
Lead Inspector Chinonye Nwankpa (000715)	**Inspector Digital Signature** Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2023.10.13 13:32:39 -04'00'
Additional Inspector(s) Ann McGregor (000704)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18-20 and 22, 2023

The following intake(s) were inspected in this Critical Incident inspection:

- Intake: #00020153 – CI 2832-000002-23 – Related to an incident that resulted in a change in a resident's condition
- Intake: #00021892 – CI 2832-000003-23 – Related to falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident had an unwitnessed fall and sustained an injury.

A Registered Practical Nurse (RPN) reported that the resident had an unsteady gait and walked without the use of an assistive aide but would have benefitted from the use of an assistive device. The Physiotherapist (PT) reported that the resident was being trialed with the use of the assistive device however, this was not documented in their plan of care. The PT loaned the assistive device to the resident and verbally communicated this to the staff on the unit. The PT verified that this information should have been documented in the resident's plan of care for the staff to implement on the unit as part of their fall prevention strategy.

The Registered Nurse (RN) was unaware that the resident required the use of the assistive device and was unable to locate the documentation that indicated how the device should be implemented for the resident. Associate Director of Care (ADOC)/Falls Lead confirmed that there was a gap related to the missing information on the use of the assistive device for the resident.

Failing to provide clear directions to staff increased the risk of not providing the resident with the appropriate assistive device required for ambulation, which also increased their risk of falls.

Sources: Resident's clinical records, Critical Incident report, Home's Fall Prevention and Management Policy; interviews with RPN, RN, ADOC Falls Lead, and PT. [000704]

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #002 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)]:
The licensee shall:

1. Re-educate the identified RPN and (Personal Support Workers) PSWs on the home's Safe Resident Handling policy, including all its appendices (attachments (a) to (m)).
2. Re-educate the identified RPN and PSWs on the home's Fall prevention and Management policy.
3. Re-educate the identified RPN and PSWs on the home's Monitoring of Resident's weight policy.
4. Maintain a record of all the education, including the content provided, date, signatures of staff who attended the education and the person who provided the education.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
Two PSWs confirmed that when they assisted the resident to have their weight measured, the resident fell and sustained injuries.

The home's Monitoring of Resident's Weights policy directs staff to select the safest method to weigh residents, and for the specific weighing device to be used for residents with specific abilities.

The resident previously requested to be weighed in a specific manner because they were concerned about falling, but this was not changed. PT, ADOC, and DOC acknowledged that the resident did not have the ability to stand unassisted for weight measurement. The DOC confirmed the resident was unsafe when they were positioned on this device, and that it should not have been used.

The resident sustained injuries from a fall when staff used an unsafe positioning technique.

Sources: Resident's clinical records, Monitoring of Resident's Weights policy; interviews with resident, PSWs, PT, ADOC, and DOC. [000715]

ii) A resident sustained a fall while being assisted by staff. The PSW, RPN, and DOC verified that the resident was immediately picked up by three staff right after they fell. RPN and PSW acknowledged that three staff manually transferred the resident by pulling the resident's underarm and lifting them off the floor.

The home's Falls Prevention and Management policy directed staff to ensure residents who fall are not moved if there is suspicion or evidence of injury. The policy further stated to mobilize the resident post-fall, staff were to use the appropriate lifting procedure and to observe for certain symptoms. This policy also noted that after a fall, the resident should not be moved before the completion of a preliminary assessment by the nurse which includes vital signs, pain, limited range of motion of joints, and checking for evidence of gross injury.

The home's Safe Resident Handling policy noted that safe resident handling procedures were to be promoted to ensure the safety of all residents, consistent with the Zero Lift policy. Furthermore, the home's Transferring a Resident policy directed staff to follow proper positioning techniques when moving a resident to prevent injury and to refrain from grasping the resident under the axilla to avoid shoulder injury to the resident.

The RPN and PSW noted that the resident did not participate in the transfer after the fall and had reported certain symptoms before staff transferred them off the floor.

The PSW verified that no assessment was completed post-fall before being transferred off the floor. The RPN confirmed that they had not completed the preliminary assessment or the transfer assessment because the resident was transferred immediately after they fell.

The DOC confirmed that when the resident exhibited certain symptoms after falling, the staff were expected to have used a specific device for the transfer off the floor as per the Home's policy and procedure.

There was risk of further injury when staff used an unsafe technique to transfer the resident after the fall incident.

Sources: Resident's clinical records, Safe Resident Handling policy, Falls Prevention & Management policy, Transferring a Resident Policy; interviews with PSW, RPN, ADOC, and DOC. [000715]

This order must be complied with by November 6, 2023

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.