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
Aug 26, 2020	2020_736689_0014	015940-20	Critical Incident System

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Westmount Gardens Long Term Care Home
590 Longworth Road LONDON ON N6K 4X9

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

CASSANDRA ALEKSIC (689)

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): August 17 & 18, 2020.

The following intakes were inspected during the Critical Incident System Inspection:

Log #015940-20 / CIS 2878-000043-20 related to transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Manager of Resident Care, the Rehabilitation Coordinator, the Resident Care Coordinator, Personal Support Workers, and residents.

The Inspector also reviewed resident clinical records, conducted resident observations and reviewed the home's policies, procedures and manuals.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 techniques when assisting a resident.

Critical Incident System (CIS) report # 2878-000043-20 submitted to the Ministry of Long-

Term Care (MLTC) on a specific date, documented an incident that caused improper/incompetent treatment of a resident that resulted in harm or risk to the resident. The report stated that resident #001 had fallen off equipment which resulted in the resident being transferred to hospital. The resident sustained injuries.

The home's policy related to the use of equipment stated that a part of the equipment should be applied to the resident and that the resident must be able to maintain proper positioning when in use. The policy also stated that the part of the equipment should be applied according to the instructions.

The home's policy Resident Plan of Care stated the following:
-"10. On-coming team members will consult the RCP [Resident Care Plan] for each resident in his/her care prior to initiating any care."

The Minimum Data Set (MDS) annual assessment was reviewed in Point Click Care (PCC) and indicated that resident #001 required the support of two-person physical assist.

The Care Plan showed the resident required assistance for transferring related to physical limitations. The care plan indicated interventions related to transferring which included support of two-person physical assistance.

On a specific date, a Personal Support Worker (PSW) stated that they attended to the resident on the date of the incident. They stated that the resident required assistance with personal care. The PSW said that their colleague was on break at the time, so they independently transferred the resident to the equipment. The PSW stated how they applied the equipment stating that parts of the equipment would not fit around the resident. TPSW stated that they provided the resident personal care and when finished, they used the equipment to transfer the resident. The PSW said that they were about to ring the call bell for additional staff assistance with transferring, and the resident fell of the equipment onto the floor. The PSW could not state whether parts of the equipment had come unattached during or after personal care, but that it was not attached correctly. The PSW confirmed that the resident was a two person transfer but had not reviewed the plan of care prior to providing personal care. When asked, the PSW stated that they had not received training related to the equipment used or transfers within the past year.

The investigative notes were reviewed and identified that the residents plan of care was not reviewed by the staff member prior to providing care and the PSW did not transfer

the resident with two-person physical assistance. The notes also documented that the PSW stated that they had not received annual training related to the equipment. Copies of the equipment and resident plan of care policies were included within the investigative folder and indicated sections of the polices that were not followed.

The manual related to instructions for use for the equipment which was used for resident #001 on the date of the incident was reviewed. The manual documented directions for use. The manual indicated how the equipment should be attached, how the resident would be positioned on the equipment and how to ensure resident safety.

On a specific date, the Manager of Resident Care (MRC) stated that they completed the investigation related to the incident. Inspector reviewed the investigation notes and identified that the PSW had not followed the plan of care for resident #001 on the date of the incident related to transferring. The MRC stated that they would expect that the staff member had reviewed the plan of care prior to providing personal care to the resident. The notes also identified that the PSW did not receive annual training related to the equipment. The MRC was not able to provide documentation or records to show the specific details of the equipment training provided as part of the home’s 2019 annual training and that the current year training was to commence September 2020. The MRC informed the inspector of the "correct" use of the equipment that was educated to staff in the home post incident. When asked how the home determined what the “correct” versus “incorrect” use of the equipment was, the MRC stated that it was based on the manual. The inspector reviewed the manual with the MRC and identified that the directions provided to the staff were different than what was recommended by the manual.

The licensee had failed to ensure that staff used two-person for physical assistance with transferring, had received annual training or had applied the equipment as per the manuals instructions for use, when assisting resident #001 during personal care. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 28th day of August, 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

Ordre(s) de l'inspecteur

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

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) :	CASSANDRA ALEKSIC (689)
Inspection No. / No de l'inspection :	2020_736689_0014
Log No. / No de registre :	015940-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 26, 2020
Licensee / Titulaire de permis :	Steeves & Rozema Enterprises Limited 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	Westmount Gardens Long Term Care Home 590 Longworth Road, LONDON, ON, N6K-4X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angie Heinz

To Steeves & Rozema Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 36.

Specifically, the licensee must:

a) Ensure the Personal Support Worker (PSW) and all staff who provide direct personal care, are trained as per the equipment manuals on safety and instructions for use, including the specific equipment used for the resident. The home must keep a written record of the names of staff who received the training, date of training, who provided the training and any training materials used.

b) Ensure resident #001, and all residents who require the use of the specific equipment for transferring, are reassessed according to the manufacturers criteria for safety and appropriate positioning, including but not limited to, weight requirements, supports, and understanding of instruction and safety. The home must keep a written record of the reassessment, including the name of resident, date of assessment, weight, supports needed, understanding of instruction and safety, and equipment type to be used.

c) Ensure that resident #001, and all residents that were reassessed as per part b) of the order, have their plan of care updated to reflect the equipment type to be used. The home must ensure that all staff who provide direct personal care to the residents are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Grounds / Motifs :

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

Critical Incident System (CIS) report # 2878-000043-20 submitted to the Ministry of Long-Term Care (MLTC) on a specific date, documented an incident that caused improper/incompetent treatment of a resident that resulted in harm or risk to the resident. The report stated that resident #001 had fallen off equipment which resulted in the resident being transferred to hospital. The resident sustained injuries.

The home's policy related to the use of equipment stated that a part of the equipment should be applied to the resident and that the resident must be able to maintain proper positioning when in use. The policy also stated that the part of the equipment should be applied according to the instructions.

The home’s policy Resident Plan of Care stated the following:
-“10. On-coming team members will consult the RCP [Resident Care Plan] for each resident in his/her care prior to initiating any care.”

The Minimum Data Set (MDS) annual assessment was reviewed in Point Click Care (PCC) and indicated that resident #001 required the support of two-person physical assist.

The Care Plan showed the resident required assistance for transferring related to physical limitations. The care plan indicated interventions related to transferring which included support of two-person physical assistance.

On a specific date, a Personal Support Worker (PSW) stated that they attended to the resident on the date of the incident. They stated that the resident required assistance with personal care. The PSW said that their colleague was on break at the time, so they independently transferred the resident to the equipment. The PSW stated how they applied the equipment stating that parts of the equipment would not fit around the resident. TPSW stated that they provided the resident personal care and when finished, they used the equipment to transfer the resident. The PSW said that they were about to ring the call bell for additional staff assistance with transferring, and the resident fell of the equipment onto the floor. The PSW could not state whether parts of the equipment had come unattached during or after personal care, but that it was not attached correctly. The PSW confirmed that the resident was a two person transfer but had not

reviewed the plan of care prior to providing personal care. When asked, the PSW stated that they had not received training related to the equipment used or transfers within the past year.

The investigative notes were reviewed and identified that the residents plan of care was not reviewed by the staff member prior to providing care and the PSW did not transfer the resident with two-person physical assistance. The notes also documented that the PSW stated that they had not received annual training related to the equipment. Copies of the equipment and resident plan of care policies were included within the investigative folder and indicated sections of the polices that were not followed.

The manual related to instructions for use for the equipment which was used for resident #001 on the date of the incident was reviewed. The manual documented directions for use. The manual indicated how the equipment should be attached, how the resident would be positioned on the equipment and how to ensure resident safety.

On a specific date, the Manager of Resident Care (MRC) stated that they completed the investigation related to the incident. Inspector reviewed the investigation notes and identified that the PSW had not followed the plan of care for resident #001 on the date of the incident related to transferring. The MRC stated that they would expect that the staff member had reviewed the plan of care prior to providing personal care to the resident. The notes also identified that the PSW did not receive annual training related to the equipment. The MRC was not able to provide documentation or records to show the specific details of the equipment training provided as part of the home's 2019 annual training and that the current year training was to commence September 2020. The MRC informed the inspector of the "correct" use of the equipment that was educated to staff in the home post incident. When asked how the home determined what the "correct" versus "incorrect" use of the equipment was, the MRC stated that it was based on the manual. The inspector reviewed the manual with the MRC and identified that the directions provided to the staff were different than what was recommended by the manual.

The licensee had failed to ensure that staff used two-person for physical assistance with transferring, had received annual training or had applied the

equipment as per the manuals instructions for use, when assisting resident #001 during personal care.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was isolated and affected one resident in the home. The home had a compliance level of 2 as they do not have a history with this section of the LTCHA. (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 27, 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:

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 26th day of August, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Cassandra Aleksic

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