Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2018	2018_543561_0002	001317-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

Sheridan Villa
2460 Truscott Drive MISSISSAUGA ON L5J 3Z8

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

DARIA TRZOS (561), DIANNE BARSEVICH (581), KELLY HAYES (583), NATASHA JONES (591), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 18, 19, 22, 23, 24, 25, 26, 29, 30, and 31, 2018.

The following intakes were completed concurrently with this Resident Quality Inspection (RQI):

Critical Incident System (CIs) inspections with the following log numbers: 019838-16 – alleged staff to resident abuse

025402-16 – alleged staff to resident abuse
029346-16 - injury of unknown cause
002866-17 – alleged staff to resident abuse
003252-17 – responsive behaviours
006904-17 – fall with injury
007323-17 – fall with injury
007784-17 – staff to resident abuse
013859-17 – injury during transfer
020895-17 – choking and fall with injury

Complaint inspections with the following log numbers:
008524-17 – multiple concerns related to care
012838-17 – multiple concerns related to care
009940-17 – several care issues and alleged abuse
020783-17 – concerns related to medications
024833-17 – multiple concerns related to care
025709-17 – multiple concerns related to care
028043-17 – multiple concerns related to care

The following inquiries were completed with the following log numbers:
005957-16 – alleged staff to resident abuse
019710-16 – alleged staff to resident abuse
020598-17 – concerns related to resident care
021579-17 – alleged staff to resident abuse
024739-17 – fall with injury and death
017837-17 – plan of care
022755-17 - responsive behaviours

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOCs), Program Support Nurse, Activation and Volunteer Services Supervisor, Facility Services Supervisor (FSS), Registered Dietitian (RD), Food Services Supervisor, Acting Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Behaviour Supports Ontario (BSO) Nurse, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, President of the Residents' Council, Family Council representative, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed residents' clinical records, investigative notes, staff education records, program evaluations, reviewed the Family Council questionnaire completed by the Council, reviewed minutes from Resident Council meetings, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **5 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	Legendé 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) Review of the written plan of care for resident #010 identified they required an identified type of transfer. On an identified date in 2016, PSW staff reported to registered

staff that they observed that resident might have an injury. Resident was assessed and transferred to hospital for further assessment. The resident's SDM requested an investigation of the incident as there was no record of what may have occurred.

Review of the home's investigation notes identified that PSW #102 on an identified date provided an unsafe transfer to the resident. They stated during an interview with the SOC #003 that they were aware of the transfer status and confirmed that they used an unsafe transfer that day.
Interview with the SOC #003 confirmed that PSW #102 provided improper care when they did not transfer the resident using the proper safe transferring techniques and they sustained an injury. (581)

This area of non-compliance was identified during a Critical Incident System (CIS) inspection, log #029346-16, conducted concurrently during this Resident Quality Inspection (RQI).

B) On an identified date in 2017, resident #020 was transferred by PSW #111 and PSW #118 using equipment as indicated in the plan of care. During the transfer resident #020 sustained an injury. The resident was transferred to hospital and required treatment.

A review of resident #020's plan of care at the time of the incident, identified the resident was using an identified equipment for transfers.
Through the home's investigation of the incident, which included interviews with the staff involved, review of documentation and an inspection of the equipment by the vendor the home concluded the following occurred:
- Improper use of the equipment
- Failure to inspect, and insert a part of the equipment that provided safety of the resident.

Through a demonstration and interview completed with SOC #001 and SOC #002 on an identified date in 2018, that they confirmed during the home's investigation that the equipment was in good repair at the time of the incident. It was identified that the wrong size of the equipment was used for resident #020 during the transfer and that the pieces that belonged to the equipment had not been reinserted properly which provided support to the resident and that the staff did not complete the required safety checklist prior to using the equipment.
In an interview with the SOC #001 and SOC #002 it was confirmed that staff did not use safe transferring devices or techniques when assisting resident #020.

This area of non-compliance was identified during a CIS inspection, log #013859-17, conducted concurrently during this RQI. [s. 36.]

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Review of the plan of care for resident #010 identified they sustained an injury on an

identified date in 2016, from an improper transfer.

Review of the Minimum Data Set (MDS) assessment on an identified date in 2016, did not identify the resident had an injury in the past 180 days. Review of the Resident Assessment Protocol (RAP) indicated that they had a fall resulting in an injury.

Interview with the Acting RAI Coordinator stated the resident did not fall but sustained an injury. They confirmed that the MDS assessment and the RAP assessment were not integrated and consistent with each other.

This area of non-compliance was identified during a CIS inspection, log #029346-16, conducted concurrently during this RQI.

B) On an identified date in 2017, resident #017 fell and sustained an injury. Review of the MDS assessment on an identified date in 2017, did not identify the resident had a fall in the past 30 days. Interview and review of the plan of care including the post fall assessment with the Acting RAI Coordinator confirmed the resident did fall in the past 30 days and confirmed that the MDS assessment and the post fall assessment were not integrated and consistent with each other.

This area of non-compliance was identified during a CIS inspection, log #007323-17, conducted concurrently during this RQI. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A dining observation of the supper dining service was completed on an identified date during this inspection, on an identified unit.

Resident #031 was observed demonstrating an identified behaviours during the first 20 minutes of the meal service.
Resident #031's plan of care was reviewed with SOC #003 and the Administrator when they arrived during the meal service and it was confirmed that the nutrition care plan intervention directed staff to implement an intervention for resident #031. This resident was assessed to be at an identified nutrition risk and the management requested staff to provide the required intervention.

Later in the service resident #031 finished their main course, the staff left and a different

course of the meal was placed in front of them. The resident again started demonstrating a behaviour. Resident waited until assistance was provided. Resident's nutrition care plan was not provided as directed in the plan of care.

B) Resident #030 was observed being provided assistance with their meal. When the resident communicated they had enough, staff left the table and a portion of their meal was left in front of them. Resident #030 was observed drinking fluids with difficulty. Later in the service, a plate was placed in front of the resident before staff were available to assist. The resident waited approximately several minutes for assistance.

Resident #030's plan of care was reviewed and it was identified the resident was at an identified nutrition risk with specific interventions in place for staff to follow while feeding. Resident #030 was on a feeding program but the care plan had specific interventions and direction for staff during meals. The plan of care also directed staff not to provide one of the interventions that were observed provided to resident.

In an interview with the Registered Dietitian (RD) it was confirmed the above interventions were in place as per the plan of care.

There were PSWs and registered staff present in the dining room who provided feeding assistance throughout the dinner service to the residents.

In an interview with the RD, it was confirmed resident #030's and #031's nutrition care plan was not provided as directed in their plans of care. (583)

C) A Critical Incident (CI) report was submitted to the Director on an identified date in 2017 related to alleged staff to resident abuse. The home completed an investigation; however, it was inconclusive and could not be substantiated.
During the investigation, the interview with PSW #122 confirmed that they did not follow resident's plan of care during the time of the incident.

The investigation notes were reviewed by LTCH Inspector. The investigation notes indicated that the home could not confirm the alleged abuse; however, in the interview with the home PSW confirmed that they did not follow resident's plan of care related to the level of care required.

The written plan of care at the time of the incident was reviewed.
LTCH Inspector was not able to interview the PSW.

Resident was no longer in the home.

The SOC #003 confirmed in the interview with LTCH Inspector that the alleged abuse could not be substantiated; however, did confirm that PSW #122 did not provide care to the resident as specified in the plan related to the level of care. (561)

This non-compliance was issued as a result of a CIS inspection log #002866-17, conducted concurrently with this RQI.

D) On an identified date in 2018, resident #017 sustained a fall with injury. Review of the Post Falls Assessment identified that a falls intervention was not implemented at the time of the fall. Review of the written plan of care indicated that this interventions was in place at the time of the fall as the resident was at an identified risk of falls. Interview with RN #116 confirmed that the intervention was to be in place and that the care set out in the plan of care was not provided to the resident as specified in the plan.

During this inspection, the resident's room was observed with PSW #112 and revealed the intervention as specified in the plan was not in place. They stated the resident used to have this intervention in place but they were not able to recall how long ago. Interview and review of the written plan of care with RPN #114 identified the resident was to have this intervention in place as they were at risk of falls and confirmed the care set out in the plan of care was not provided to the resident as specified in the plan.

This non-compliance was identified during a CIS inspection, log #007323-17, conducted concurrently during this RQI. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #016 sustained falls in 2017 and after one of them sustained injuries. Review of the plan of care identified when the resident was readmitted from hospital, their transfer status was reassessed and the resident required a different type of transfer. Review of the written plan of care identified that it was not revised after the change.

Interview with PSW #104 stated that resident's transfer status changed after readmission. Interview and review of the written plan of care with the Acting RAI Coordinator stated the resident's condition changed after the injury and required different

interventions. They confirmed that the plan of care was not reviewed and revised when their care needs changed after the injury.

This non-compliance was identified during a CIS inspection, log #006904-17, conducted concurrently during this RQI. [s. 6. (10) (b)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Two complaints were submitted to the Director on two different dates in 2017 with the concerns expressed by the representative of resident #027.

Review of the most recent resident's plan of care indicated that they had an intervention in place to address the concern identified by the resident's representative.
The resident's observations conducted on multiple occasions during inspection, indicated that the care was provided to the resident as specified in the plan of care.

PSW #109 was interviewed and indicated that once care was provided to the resident, it was to be recorded in Point of Care (POC). Review of TASK records in Point Click Care (PCC) indicated no documentation for this specific intervention was identified on multiple days in 2017 and 2018.
The Acting RAI Coordinator indicated that PSW #122 confirmed that care was provided to the resident; however, they forgot to record it in POC.

The policy titled "Residents' Care and Service Section, Documentation - electronic health records subject", policy number LTC9-05.11.06, last updated and reviewed May 12, 2014, indicated that "all PSW staff shall complete documentation for all care tasks in the electronic health record documentation system and other documentation tools as assigned" and the PSW staff shall "accurately document care tasks at the time they are completed at regular intervals throughout the shift".

The Program Support Nurse, the SOC #002 and the Acting RAI Coordinator, indicated that the specific interventions for resident #027 were not documented by the nursing staff, which was acknowledged by the DOC.

This non-compliance was identified during Complaint inspections, log #024833-17 and #025709-17, conducted concurrently during this RQI.

B) A complaint was received by the Director on an identified date in 2017 with the concerns about care expressed by the representative of resident #027.
Review of the most recent resident's plan of care indicated that they were on a specific routine for the care identified.

PSW #113 and PSW #112 were interviewed and both indicated that the resident was on a specific schedule for continence care. PSW #109 indicated that once care was provided to the resident, it was to be recorded in POC.

The resident's observations conducted on multiple occasions during this inspection indicated that the care was provided to the resident as specified in the plan.

Review of the specific TASK records in PCC completed by the front line staff members indicated no documentation completed by night shifts staff when the care was completed for the resident on multiple days in 2017 and 2018.

The Acting RAI Coordinator indicated that PSW #125 confirmed that the care was provided for the resident on an identified date in 2017 and staff forgot to document it. PSW #127 indicated to the LTCH Inspector that the care was provided on multiple days in 2017 and 2018, and they thought that they documented it in POC.

The Program Support Nurse, the SOC #002, and the Acting RAI Coordinator indicated that interventions for the specific care for resident #027 were not documented by the nursing staff, which was acknowledged by the DOC.

This non-compliance was identified during Complaint inspection, log #024833-17, conducted concurrently during this RQI. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A) Review of the progress notes identified that on an identified date in 2016, resident #019 had an alteration in skin integrity. Review of the clinical health record revealed that a skin and wound assessment was not completed when the altered skin impairment was identified. Interview with Acting RAI Coordinator confirmed the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound.

B) On an identified date in 2016, documentation in the progress notes identified that resident #019 had a alteration in the skin integrity in a different location. Review of the clinical health record revealed that a skin and wound assessment was not completed when the alteration was identified by family. Interview with the Acting RAI Coordinator confirmed the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound.

C) On an identified date in 2017, documentation in the progress notes identified that

resident #019 had an alteration in the skin integrity. Review of the plan of care indicated that an initial skin and wound assessment was not completed by registered staff when the skin alteration was identified. Interview and review of the clinical health record with RPN #101 confirmed that an initial skin and wound assessment was not completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

D) On an identified date in 2017, resident #019 was identified with an alteration in the skin integrity. Review of the plan of care revealed that a skin and wound assessment was not completed when the altered skin integrity was identified. Interview with the Program Support Nurse and review of the clinical health record revealed that the initial skin and wound assessment was not completed until few days later and should have been completed when it was first identified using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

This non-compliance was identified during Complaint inspections, log #009940-17 and 028043-17, conducted concurrently during this RQI. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #027 was at risk for skin breakdown and pressure ulcers related to multiple health conditions.The resident developed alterations in skin integrity on identified dates in 2017. Review of the resident's plan of care did not contain records related to at least weekly skin and wound assessment of the alterations in the skin integrity. RPN #114 was interviewed and indicated that it was the home's expectations that weekly skin and wound assessments were completed by the registered staff members. Review of the home's Skin and Wound Care Program, revised on June 27, 2016, indicated that the resident was to be reassessed weekly until altered skin integrity was healed. The SOC #002, the DOC and the Program Support Nurse indicated that no records were identified that the weekly skin assessments for resident #027 were completed on the identified dates. (632)

This non-compliance was identified during Complaint inspections, log #024833-17 and #025709-17, conducted concurrently during this RQI.

B) Resident #028 had a health condition and was at risk for skin breakdown and

pressure ulcers. The resident developed an alteration in the skin integrity on an identified date in 2017. Review of the resident's plan of care did not contain records related to at least weekly skin and wound assessment completed for the alteration in the skin integrity for identified weeks. RPN #114 was interviewed and indicated that it was the home's expectations that weekly skin and wound assessments were completed by the registered staff members. Review of the home's Skin and Wound Care Program, revised on June 27, 2016, indicated that the resident was to be reassessed weekly until altered skin integrity was healed. The Program Support Nurse indicated that no records were identified that at least weekly skin assessment for resident #028 was completed on the identified dates, which was acknowledged by the DOC. (632)

C) On an identified date in 2016, resident #019 was observed by registered staff with an alteration in the skin integrity. Review of the clinical health record revealed that weekly skin and wound assessments were not completed by registered staff until the skin alteration was resolved. The clinical health record review did not identify when the resident's alteration in skin integrity has healed. The Acting RAI Coordinator confirmed that the staff were required to complete the weekly skin and wound assessments for the skin alteration.

D) On an identified date in 2016, progress notes identified that resident #019 sustained an alteration in the skin integrity. Review of the clinical health record identified that weekly skin and wound assessments were not completed by registered staff. The clinical health record review did not identify when the resident's alteration in skin integrity has healed. The Acting RAI Coordinator confirmed that the staff were required to complete the weekly skin and wound assessments for this resident.

E) On an identified date in 2017, the skin and wound assessment identified that resident #019 had altered skin integrity. Review of the plan of care identified that one weekly skin and wound assessment was not completed during the time when resident continued to have the altered skin integrity. Interview with the Acting RAI Coordinator confirmed that one of the weekly skin and wound assessments were not completed before the skin impairment has healed.

The above non-compliance related to resident #019 was identified during Complaint inspections, log #009940-17 and #028043-17, conducted concurrently during this RQI. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that it was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Resident #027 was admitted to the home on an identified date with an identified status of continence care. RN #115 was interviewed and indicated that it was the home's

expectation that each resident's bladder and bowel continence were assessed and the assessments were documented in assessment tab in PCC. Review of continence assessment records indicated that the resident's incontinence was not assessed on admission. Review of the home's Continence Care and Bowel Management Program, revised on February 18, 2011, indicated that the resident was to be assessed on admission. RN #115 indicated that continence assessment for resident #027 was not completed on admission, which was confirmed by the Acting RAI Coordinator and was acknowledged by the DOC. (632)

This non-compliance was identified during Complaint inspection, log #024833-17, conducted concurrently during this RQI.

B) Resident #007 had a plan of care indicating they were incontinent of bladder and bowels. The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) reviewed quarterly assessments in 2017 indicated that resident had a deterioration on two different quarterly assessments.

The clinical records were reviewed and indicated that there was no bladder and bowel assessment completed when resident's incontinence had deteriorated in 2017. RPN #103 indicated that it was an expectation that residents were assessed using the bowel and bladder assessment when there was a change in continence. In an interview the Acting RAI Coordinator confirmed that the resident had a deterioration in bowel and bladder functioning and the registered staff were expected to complete an assessment under the assessment tab. The Acting RAI Coordinator confirmed that the assessment was not completed.

In an interview with the SOC #003 it was confirmed that the staff were expected to complete a Restorative Continence Assessment when there was a change in bowel or bladder continence.

The Continence Care and Bowel Management Program, revised October 24, 2016, indicated that the role of the registered staff was to "complete the Restorative Continence Assessment for residents with significant changes to continence as assessed in RAI MDS and after any change in health status that may affect bladder or bowel continence".

The licensee failed to ensure that resident was assessed using an assessment that was a clinically appropriate assessment instrument specifically designed for assessing continence when resident had a deterioration of incontinence. [s. 51. (2) (a)]

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 a resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that it is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident requires, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home

that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

In an interview during this RQI, resident #004's SDM indicated they had raised a concern related to an equipment purchased by the family that has gone missing. The equipment had re-appeared; however, the home never provided them with a reason of what had happened to it. The SDM indicated that currently resident was using their own equipment. The home informed them that the resident required another Occupational Therapist (OT) assessment to which they had not agreed to and questioned why the

resident needed another assessment.

The Activation and Volunteer Services Supervisor was interviewed and confirmed that the above mentioned concern was brought to their attention.
The Activation and Volunteer Services Supervisor stated that resident #004 was currently using a loaner equipment provided by the home due to the fact that resident's own was not a good fit anymore. Resident's original equipment was kept in the storage. The Activation and Volunteer Services Supervisor provided copies of emails to the LTCH Inpsector showing the communication with the SDM. The email indicated that the SDM was looking forward to hearing back from the home on this matter. The SDM in an interview with the LTCH Inspector confirmed that the home never provided a response to them.

The record review and interview with the DOC confirmed that the response to the concern was never provided to the SDM of the resident. The equipment belonging to resident #004 that the SDM had originally purchased could not be located. The SDM was not aware that the original equipment they purchased was still missing and that the resident was using a loaner one.

A review of the home's policy titled "Reporting and managing complaints and recommendations", policy number LTC1-05.05, effective April 26, 2017, indicated that every verbal or written complaint would be investigated. It further indicated that a written record and documentation would be retained for all complaints not resolved within 24 hours which would include the nature of each verbal or written complaint, the date the complaint was received, the action taken to resolve the complaint, the final resolution if any, every date on which any response was provided to the complainant and a description of the response, and any additional response made by the complainant after receiving the response.

The Activation and Volunteer Services Supervisor and the DOC confirmed that the complaints process was not followed and that the home planned to contact the SDM to discuss this issue further. [s. 101. (1)]

2. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time

frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

A) In an interview during this RQI, resident #004's SDM indicated they had raised a concern related to the equipment purchased by the family that has gone missing. The equipment had re-appeared; however, the home never provided them with a reason of what had happened to the original one. The SDM indicated that currently resident was using their own equipment. The home informed them that the resident required another assessment to which they had not agreed to.

The Activation and Volunteer Services Supervisor confirmed that the above mentioned concern was brought to their attention.
A review of the home's 2017 Complaints binder did not include a documented record of the complaints identified above.

A review of the home's policy titled "Reporting and managing complaints and recommendations", policy number LTC1-05.05, effective April 26, 2017, indicated that the supervisor who received a verbal complaint would complete the "LTC complaint or recommendation" form (IDF-010) and that every verbal or written complaint would be investigated. It further indicated that a written record and documentation would be retained for all complaints not resolved within 24 hours which would include the nature of each verbal or written complaint, the date the complaint was received, the action taken to resolve the complaint, the final resolution if any, every date on which any response was provided to the complainant and a description of the response, and any additional response made by the complainant after receiving the response.

The Activation and Volunteer Services Supervisor confirmed that the LTC complaint or recommendation form was not filled out after the concern was received by the home. (561)

B) In an interview during this RQI, resident #022's representative indicated they had raised several complaints in 2017 with the home's management regarding care.
A review of the home's investigation notes revealed the above mentioned complaints were brought to the home's attention by resident #022's representatives. The review of the investigation notes indicated that the home did not keep documentation of the raised

concerns, the date of when the concerns were brought to the home's attention, the action taken by the home to resolve the complaints and any response made to the complainant. The Administrator, DOC, SOC #003, and the BSO nurse also confirmed that the above mentioned concerns were brought to their attention. A review of the home's 2017 Complaints binder did not include a documented record of the complaints identified above.

A review of the home's policy titled "Reporting and managing complaints and recommendations", policy number LTC1-05.05, effective April 26, 2017, indicated that the supervisor who received a verbal complaint would complete the "LTC complaint or recommendation" form (IDF-010) and that every verbal or written complaint would be investigated. It further indicated that a written record and documentation would be retained for all complaints not resolved within 24 hours which would include the nature of each verbal or written complaint, the date the complaint was received, the action taken to resolve the complaint, the final resolution if any, every date on which any response was provided to the complainant and a description of the response, and any additional response made by the complainant after receiving the response.

In interviews, the DOC and SOC #003 confirmed the home did not ensure that a documented record, as per the legislation, was kept of complaints not resolved within 24 hours, raised by the representatives of resident #022.

This non-compliance was identified during Complaint inspections, log #008524-17, #012838-17, #020783-17, conducted concurrently during this RQI. [s. 101. (2)]

3. The licensee failed to ensure that the documented record of complaints was reviewed and analyzed for trends at least quarterly, the results of the review and analysis were taken into account in determining what improvements are required in the home; and that a written record was kept of each review and of the improvements made in response.

A review of the home's document titled "Home Specific Evaluation Tool – Continuous Quality Improvement", dated December 20, 2017, included an annual review of the home's complaint procedures; however, a quarterly review of the documented complaint records was not included.

A review of the home's 2016 and 2017 "Complaints" binder included several complaints raised by residents and family members, documented on the home's "LTC Complaint or Recommendation" form #IDF-010; however, a quarterly review of the documented

complaint records was not included.

A review of the home's policy titled "Reporting and managing complaints and recommendations", policy number LTC1-05, effective April 26, 2017, indicated that the home would review and analyze all documented complaints for trends at least quarterly, the results would be considered to determine improvements, and a written record would be kept of each review.

A review of the home's policy titled "CQI - Annual Resident Care and Services Program Evaluation", policy number LTC1-09.06, effective December 4, 2014, indicated the Complaints Management Program would be evaluated annually; however, it did not include the requirement to complete quarterly reviews of the documented complaint records for trends.

In interviews, the Administrator and DOC confirmed the home did not complete quarterly reviews of documented complaint records for trends.

This non-compliance was identified during Complaint inspections, log #008524-17, #012838-17, #020783-17, conducted concurrently during this RQI. [s. 101. (3)]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as stated in Reg. 79/10, s. 101 (1) and that a documented record is kept in the home of the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant; and to ensure that a documented record is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home, and a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation 79/10, s.48, the licensee is required to ensure that the interdisciplinary programs including a falls prevention and management program, was developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

A) The home's program titled "Minimal Lift Program", revised in March 2011, directed registered staff under the 'Resident Assessment of Initial transfer/lift assessment' to complete an initial transfer/lift assessment found on PCC upon admission and/or readmission.

Resident #016 sustained falls, on identified dates in 2017, and after the one of the falls sustained an injury and was admitted to hospital. Review of the plan of care when the resident was readmitted identified that the transfer/lift assessment was not completed in PCC. Interview and review of the clinical health record with the Program Support Nurse confirmed that the transfer/lift assessment was not completed when the resident was readmitted and the home's policy was not complied with.

This non-compliance was identified during a CIS inspection, log #006904-17, conducted concurrently during this RQI.

B) Review of the home's Falls Prevention and Management Program, revised on October 24, 2016, directed registered staff to initiate the head injury routine (HIR) for all unwitnessed falls with suspected head injury and as clinically indicated. Furthermore, it directed staff to complete the HIR for 28 hours, monitor and document resident status every shift for an additional 44 hours (for a total of 72 hours) post fall, including assessment of vital signs or injury and record assessment in the progress notes.

On an identified date in 2018, resident #017 had an unwitnessed fall and sustained an altered skin integrity. Review of the HIR revealed that it was initiated post fall; however, was not completed for the entire 28 hours. Interview and review of the HIR documentation with RN #116 confirmed that it was not completed every four hours for 20 hours post fall and the home's policy was not complied with.

This non-compliance was identified during a CIS inspection, log #007323-17, conducted concurrently during this RQI. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with:
1. All doors leading to stairways and the outside of the home must be,
i. kept closed and locked,
ii. equipped with a door access control system that was kept on at all times, and
iii. equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and,
A. was connected to the resident-staff communication and response system, or
B. was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

An observation during the initial tour of the home revealed the door leading to the balcony outside was unlocked and unsupervised. When the door was opened, no alarm was activated. At the time of the observation, two residents were sitting in the lounge nearby. No staff were present.
In an interview, RPN #114 confirmed the door was not locked and the alarm was not activated when the door was opened. The RPN notified the maintenance department immediately. The home implemented monitoring during the time at which the door was unlocked until the home was able to fix the door.

In an interview, the Facility Services Manager (FSS) confirmed the magnetic lock was not functioning, therefore the door was unlocked, but should have been locked. The malfunctioning door had not been reported by the staff as per the FSS, and was not noted during the monthly audit of the doors in the home. They further confirmed the lock was fixed the following day.

The home did not ensure all doors leading to the outside of the home were kept locked. [s. 9. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

A dining observation of the meal service was completed on an identified unit during this RQI.

A) A review of resident #031's plan of care identified they required interventions in place during meal service, which during the observation were not provided to the resident. Courses of the meal were served prior to staff being able to assist the resident. Resident had to wait several minutes for assistance.

B) Resident #030 was observed during the meal and was not provided with interventions that were in place as per resident's plan of care which was specific to the level of assistance and aids required. Courses of the meal were served prior to staff being able to assist the resident. Resident had to wait several minutes for assistance.

Resident #030's plan of care was reviewed and it was identified the resident was at nutritional risk and required specific strategies during meal service.
There were PSWs and registered staff present in the dining room throughout the meal service.

In an interview with the RD it was confirmed resident #030 and #031 required assistance and that staff were not to serve their meals until staff were available to provide the required assistance. [s. 73. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly evaluation of the medication management system included at least:
(a) review of drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk
(b) review of reports of any medication incidents and adverse drug reactions referred to in sections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act, and
(c) identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

In an interview, SOC #003 indicated the home conducted monthly reviews of the medication management system in their Health Services Leadership team meetings and in their Leadership meetings.
A review of the Health Services Leadership team meeting minutes and Leadership meeting minutes did not include a review of drug utilization trends and drug utilization patterns, and did not include a review of reports of any medication incidents and adverse drug reactions and all instances of the restraining of residents by the administration of a drug when immediate action was necessary.

A review of the home's policy titled "Medication – Adverse Drug Reaction - Reporting", policy number LTC 09-05.12.13, effective June 10, 2013, indicated a quarterly review of all adverse drug reactions would be completed and potential strategies to decrease further occurrences would be implemented. The home's policy titled "Medication – Incidents", policy number LTC09-05.12.11, effective June 10, 2013, did not direct the home to conduct quarterly reviews.

In an interview the Administrator and DOC confirmed the home did not complete quarterly reviews of the medication management system for the year 2016. [s. 115. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year as referred to in section 115.

A review of the home's documents did not include quarterly evaluation of the medication management system in 2016.
In an interview, SOC #003 confirmed the home did not conduct quarterly evaluations of the medication management system.
In an interview, the Administrator indicated the home conducted an annual review of the home's medication management system, and produced a document titled "Home Specific Evaluation Tool – Medication Management system", dated February 28, 2017, which detailed the review. The above mentioned document did not include a review of the quarterly evaluations in 2016. [s. 116. (3)]

Issued on this 27th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), DIANNE BARSEVICH (581), KELLY HAYES (583), NATASHA JONES (591), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2018_543561_0002
Log No. / No de registre :	001317-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2018
Licensee / Titulaire de permis :	The Regional Municipality of Peel 7120 Hurontario Street, 6th Floor, MISSISSAUGA, ON, L5W-1N4
LTC Home / Foyer de SLD :	Sheridan Villa 2460 Truscott Drive, MISSISSAUGA, ON, L5J-3Z8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Griffin

To The Regional Municipality of Peel, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The licensee shall do the following:

1. The licensee shall ensure that resident #010 and all other residents that require assistance with transfers are transferred according to their plans of care and according to the home's policies and procedures.

2. The licensee shall ensure that the plans of care provides clear direction to staff as to what size and type of sling is used for each resident that requires it.

3. The licensee shall complete an audit of the safety checklist completed by PSWs for all residents that are using identified equipment. The home shall keep records of the audit.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the Licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a compliance order (CO) due to severity level of 3 (actual harm), scope level of 1 (isolated) and compliance history level of 2 (previous non-compliance unrelated), in respect of the actual harm that resident #010 and resident #020 experienced, the scope of isolated incident, and the Licensee's history of unrelated non-compliance in the area of improper transferring and positioning techniques.

The licensee failed to ensure that staff used safe transferring and positioning

devices or techniques when assisting residents.

A) Review of the written plan of care for resident #010 identified they required an identified type of transfer. On an identified date in 2016, PSW staff reported to registered staff that they observed that resident might have an injury. Resident was assessed and transferred to hospital for further assessment. The resident's SDM requested an investigation of the incident as there was no record of what may have occurred.

Review of the home's investigation notes identified that PSW #102 on the identified day provided an unsafe transfer to the resident. They stated during an interview with the SOC #003 that they were aware of the transfer status and confirmed that they used an unsafe transfer that day.
Interview with the SOC #003 confirmed that PSW #102 provided improper care when they did not transfer the resident using the proper safe transferring techniques and they sustained an injury. (581)

This area of non-compliance was identified during a Critical Incident System (CIS) inspection, log #029346-16, conducted concurrently during this Resident Quality Inspection (RQI).

B) On an identified date in 2017, resident #020 was transferred by PSW #111 and PSW #118 using equipment as indicated in the plan of care. During the transfer resident #020 sustained an injury. The resident was transferred to hospital and required treatment.

A review of resident #020's plan of care at the time of the incident, identified the resident was using an identified equipment for transfers.

Through the home's investigation of the incident, which included interviews with the staff involved, review of documentation and an inspection of the equipment by the vendor the home concluded the following occurred:
- Improper use of the equipment
- Failure to inspect, and insert a part of the equipment that provided safety of the resident.

Through a demonstration and interview completed with SOC #001 and SOC #002 on an identified date in 2018, they confirmed during the home's investigation that the equipment was in good repair at the time of the incident. It

was identified that the wrong size of the equipment was used for resident #020 during the transfer and that the pieces that belonged to the equipment had not been reinserted properly which provided support to the resident and that the staff did not complete the required safety checklist prior to using the equipment.

In an interview with the SOC #001 and SOC #002 it was confirmed that staff did not use safe transferring devices or techniques when assisting resident #020.

This area of non-compliance was identified during a CIS inspection, log #013859 -17, conducted concurrently during this RQI.
(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Daria Trzos

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