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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 31, 2019	2019_570528_0007 (A4)	007767-18, 008540-18, 015335-18, 017322-18, 021082-18, 025292-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Brierwood Gardens
425 Park Road North BRANTFORD ON N3R 7G5

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

Amended by CYNTHIA DITOMASSO (528) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

phi in public report

Issued on this 31st day of May, 2019 (A4)

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

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

Ministère de la Santé et des Soins de longue durée

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

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Brierwood Gardens
425 Park Road North BRANTFORD ON N3R 7G5

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

Amended by CYNTHIA DITOMASSO (528) - (A4)

Amended 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): February 28, 2019 and March 1, 4, 5, 6, 2019.

This inspection included the following:

Log #007767-18, #008540-18, and #021082-18 related to resident to resident abuse

Log #015335-18 related to allegations of staff to resident verbal abuse

Log #017322-18 and #025292-18 related to transferring and positioning

This inspection was completed concurrently with Follow Up Inspection #2019_570528_0008

LTC Home Inspector Emmy Hartmann #748 was present during the inspection

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, registered nurses, registered practical nurses, personal support workers, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed documents including medical records, investigation notes, meeting minutes, staffing schedules, policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A2)

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A. Review of CIS #2878-000015-18 (log #007767-18), CIS #2678-000017-18 (log #008540-18) and CIS #2678-000029-18 (log #021082-18), submitted from April to August 2018, described incident of resident to resident abuse.

i. In 2017, resident #003 was admitted to the home. The Admission MDS (Minimum Data Set) Assessment revealed that the resident had a cognitive status.

ii. Review of CIS # 2678-000015-18, from April 2018, outlined an incident where staff observed an altercation between resident #003 and resident #004. Review of the investigation notes and interview with DOC #100, in March 2019, confirmed that the incident met the definition of abuse and resident #004 was negatively affected.

iii. A progress note in April 2018, confirmed that a specific intervention was implement to prevent further incidents. For several days, the intervention was implemented with no incident, and therefore, the intervention was discontinued.

iv. A couple of days after the intervention was discontinued another incident occurred between resident #003 and resident #005. Review of investigation notes and interview with DOC #100 in March 2019, confirmed that the incident met the definition of abuse and resident #005 was negatively affected.

v. Review of progress notes confirmed that the specific intervention was re-implemented.

vi. In May 2018, charting, revealed that resident #003 had displayed responsive behaviours. Review of progress notes identified that resident #003 had an incident with resident #007. Interview with DOC #100 in March 2019, confirmed that the incident met the definition of abuse but that there was no negative outcome to resident #007.

vii. Several months later, in August 2018, an incident occurred between resident #003 and resident #006. Interview with ADOC #104 in March 2019, confirmed

that they observed the incident and the specific intervention was not implemented, as required. In addition, the ADOC confirmed that the incident met the definition of abuse but that resident #006 was not harmed.

The home failed to protect residents #004, #005, #006 and #007 from abuse by resident #003. [s. 19. (1)]

Additional Required Actions:

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

(A4)
The following order(s) have been amended: CO# 001

WN #2: 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 :

(A4)
1. The licensee failed to ensure that safe used transferring and positioning devices or techniques when assisting residents.

A. Review of CIS #2678-000030-18, log #025292-18, submitted in September 2018, identified an incident where resident #001 was injured.

i. Specifically, they failed to ensure safe transferring and positioning techniques were used, when assisting resident #001 in their device, by assisting them with activities of daily living.

ii. In September 2018, a critical incident was submitted to the Ministry of Health and identified the resident sustained an injury as a result of the incident.

iii. In March 2019, at a specific time, PSW #101 was interviewed, as they were the one who provided the resident with assistance, as requested by the resident. PSW #101 confirmed they did not put the attachment on the resident's device and the resident was injured. PSW #101 stated this is the policy of the home, to always apply the attachment to the device before assisting the residents.

iv. The plan of care, from June 2018, stated the resident required specified assistance with activities of daily living.

v. Observation of resident #001 in March 2019, revealed they had the attachments on their device.

The licensee failed to ensure resident #001 was transferred safely, using the attachment device, resulting in an injury.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions.

A. Review of CIS #2678-000029-18, log #021082-18, submitted in August 2018, identified an incident of resident to resident abuse.

i. The plan of care for resident #003 identified that the resident had a cognitive status and in April 2018 began displaying responsive behaviours. In April 2018, a specific intervention was implemented to monitor the resident.

ii. In August 2018, an incident occured between resident #003 and #006. Review of the investigation and progress notes revealed the resident's specific interventions should have been implemented at that time. Interview with ADOC #104 in March 2019, confirmed that the intervention was not implemented at the time of the incident.

The home failed to implement interventions too minimize the risk of resident #003 to co-residents. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #4: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy, or system was complied with.

A. Review of CIS #2678-000030-18, log #025292-18, submitted in September 2018, identified an incident where resident #001 was injured during activities of daily living.

i. The home's policy for attaching specified devices was not complied with.

ii. In September 2018, resident #001 was provided assistance with activities of daily living from PSW #101. The home's policy directed staff to put both attachments on the device before assisting the residents.

PSW #101 confirmed they did not follow the policy of the home resulting in an injury to resident #001. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that Abuse of a resident by anyone had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A. Review of CIS #2878-000015-18 (log #007767-18), CIS #2678-000017-18 (log #008540-18) and CIS #2678-000029-18 (log #021082-18), submitted from April to August 2018, described resident to resident altercations.

i. Resident #003 had responsive behaviours and had specific interventions to protect co-resident.

ii. In May 2018, as incident occurred between resident #003 and #007.

iii. Interview with DOC #100 in March 2019, confirmed that the incident met the definition of abuse, although, there was no negative outcome to resident #007. Interview with DOC #100 confirmed that since resident #007 had not been harmed as a result of the incident, it was not reported to the Director. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of CIS #2678-000030-18, log #025292-18, submitted in September 2018, identified an incident where resident #001 was injured during activities of daily living.

The Falls Management Program was not evaluated and updated in 2018 in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. During an interview in March 2019, the DOC confirmed this annual evaluation was not completed in 2018. [s. 30. (1) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that the responsive behaviour program was being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

Review of CIS #2878-000015-18 (log #007767-18), CIS #2678-000017-18 (log #008540-18) and CIS #2678-000029-18 (log #021082-18), submitted from April to August 2018, described resident to resident altercations.

The home's Responsive Behaviour Program Evaluation for 2017, was reviewed and included a two part review. Part one, completed in March 2018, detailed corporates best practice review, which examined the program to ensure all improvement and or changes had been implemented in homes. Part two, dated April 2018, was to include home evaluation and analysis, which was incomplete. Interview with DOC #100 in March 2019,confirmed that the second part of the program review, specific to the home, was not completed as required. [s. 53. (3) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Review of CIS #2878-000015-18 (log #007767-18), CIS #2678-000017-18 (log #008540-18) and CIS #2678-000029-18 (log #021082-18), submitted from April to August 2018, described resident to resident altercations.

The home's Resident Non-Abuse Program Evaluation for 2017, was reviewed and included a two part review. Part one, completed in March 2018, detailed corporates best practice review, which examined the program to ensure all improvement and or changes had been implemented in homes. Part two, undated, was to include the home evaluation and analysis, which was incomplete. Interview with DOC #100 in March 2019, confirmed that the second part of the program review, specific to the home, was not completed as required. [s. 99. (b)]

Issued on this 31st day of May, 2019 (A4)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by CYNTHIA DITOMASSO (528) - (A4)
Inspection No. / No de l'inspection :	2019_570528_0007 (A4)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007767-18, 008540-18, 015335-18, 017322-18, 021082-18, 025292-18 (A4)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 31, 2019(A4)
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Brierwood Gardens 425 Park Road North, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Nadeau

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A4)
The licensee must be compliant with s. 19(1) of LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that resident's #004, #005, #006, #007, and all other residents from abuse by resident #003.

The plan must include, but is not limited to:
a. current strategies/interventions in place to prevent abuse by resident #003
b. steps to ensure that resident #003 is monitored for inappropriate behaviours when interventions are changed.

Please submit the written plan, quoting log number [CIS#2019_570528_0007] and inspector Cynthia Di Tomasso by email to [HamiltonSAO.MOH@ontario.ca by April 5, 2019.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

(A4)
1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A. Review of CIS #2878-000015-18 (log #007767-18), CIS #2678-000017-18 (log #008540-18) and CIS #2678-000029-18 (log #021082-18), submitted from April to

August 2018, described incident of resident to resident abuse.

i. In 2017, resident #003 was admitted to the home. The Admission MDS (Minimum Data Set) Assessment revealed that the resident had a cognitive status.

ii. Review of CIS # 2678-000015-18, from April 2018, outlined an incident where staff observed an altercation between resident #003 and resident #004. Review of the investigation notes and interview with DOC #100, in March 2019, confirmed that the incident met the definition of abuse and resident #004 was negatively affected.

iii. A progress note in April 2018, confirmed that a specific intervention was implement to prevent further incidents. For several days, the intervention was implemented with no incident, and therefore, the intervention was discontinued.

iv. A couple of days after the intervention was discontinued another incident occurred between resident #003 and resident #005. Review of investigation notes and interview with DOC #100 in March 2019, confirmed that the incident met the definition of abuse and resident #005 was negatively affected.

v. Review of progress notes confirmed that the specific intervention was re-implemented.

vi. In May 2018, charting, revealed that resident #003 had displayed responsive behaviours. Review of progress notes identified that resident #003 had an incident with resident #007. Interview with DOC #100 in March 2019, confirmed that the incident met the definition of abuse but that there was no negative outcome to resident #007.

vii. Several months later, in August 2018, an incident occurred between resident #003 and resident #006. Interview with ADOC #104 in March 2019, confirmed that they observed the incident and the specific intervention was not implemented, as required. In addition, the ADOC confirmed that the incident met the definition of abuse but that resident #006 was not harmed.

The home failed to protect residents #004, #005, #006 and #007 from abuse by resident #003.

The severity of the issue was determined to be minimal harm (level 2) to the residents. The scope of the issue was a pattern (level 2). The home had one or more related non-compliance in the last 36 months (level 3) with a Voluntary Plan of Correction (VPC) issued in June 2018 (#2018_555506_0019). (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 12, 2019

Order # / Ordre no : 002

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 :

(A4)
The licensee must be compliant with Ontario Regulation 79/10 s. 36.

The licensee shall prepare submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan must include:
i. The development of information for direct care staff outlining the safe use of the specified device during activities of daily living.
ii. How the home will educate all direct care staff on the safe use of the devices.
iii. A process to ensure that the plans of care for all residents are updated to include safe use of the devices.
iv. An auditing system, including frequency and number of audits to be completed, to ensure that all staff are safely providing care to the residents. Records of the audits will be retained.

Please submit the written plan, quoting CIS #2019_570528_0007 and inspector Cynthia Di Tomasso by email to HamiltonSAO.MOH@ontario.ca by May 3, 2019.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

(A4)
1. The licensee failed to ensure that safe used transferring and positioning devices or techniques when assisting residents.

A. Review of CIS #2678-000030-18, log #025292-18, submitted in September 2018, identified an incident where resident #001 was injured.

i. Specifically, they failed to ensure safe transferring and positioning techniques were used, when assisting resident #001 in their device, by assisting them with activities of daily living.

ii. In September 2018, a critical incident was submitted to the Ministry of Health and identified the resident sustained an injury as a result of the incident.

iii. In March 2019, at a specific time, PSW #101 was interviewed, as they were the one who provided the resident with assistance, as requested by the resident. PSW #101 confirmed they did not put the attachment on the resident's device and the resident was injured. PSW #101 stated this is the policy of the home, to always apply the attachment to the device before assisting the residents.

iv. The plan of care, from June 2018, stated the resident required specified assistance with activities of daily living.

v. Observation of resident #001 in March 2019, revealed they had the attachments on their device.

The licensee failed to ensure resident #001 was transferred safely, using the attachment device, resulting in an injury.

The severity of the issue was determined to be actual harm (level 3). The scope of the issue was isolated (level 1). The home had one or more related non-compliance in the last 36 months (level 3) with a Voluntary Plan of Correction (VPC) issued in June 2016 (#2016_275536_0009).
(169)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 17, 2019

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:

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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 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)
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 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 31st day of May, 2019 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CYNTHIA DITOMASSO (528) - (A4)

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