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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 23, 2018	2018_631210_0005	003841-18	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 14, 15, 19 and 20, 2018

During the course of the inspection, the inspector(s) spoke with General Director, Registered Nurses, Personal Support Workers (PSW), Kinesiologist, family members, Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Ontario (BSO) program Lead.
During the course of this inspection, the inspector observed resident care, observed staff and resident interactions, reviewed resident health records and relevant policies, procedures and training records.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 licence failed to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

MOHLTC received complaints on identified dates, from resident #001's family member that the resident has sustained several injuries of unknown cause, their personal item

was damaged several times and staff transferred the resident unsafely.

During an interview with resident #001's family members they shared with the inspector that they have witnessed on several occasions in a specified period that resident #001 gets transferred during activities of daily living (ADL), by one staff only or some staff uses the sit-stand lift with one staff only.

A review of resident #001's written plan of care revealed that because of poor balance, unsteadiness, risk of falls, cognitive impairment the transferring status required extensive assistance from two team members without the use of a mechanical device. The resident required extensive assistance from two team members for toileting and related care.

A review of the video recordings in resident 001's room, revealed PSW #109 transferred the resident on four occasions during a specified month, captured using the sit to stand lift without assistance of a second staff. The resident was noted being attached to the lift with a sling, their arms hanging down and not holding the grab bars of the lift.

Interview with PSW #109 indicated they transferred resident #001 with the sit-stand lift by them self, and sometimes they would call another staff to help. They considered that using the sit-stand lift for transfer was a safe method because it was one level up from the two people side by side even though resident 001's arms were hanging down, not holding the grab bar of the lift. They indicated that the resident would hold the grab bar of the lift at the beginning of the transfer but in the meanwhile during toileting and perineal care the resident would release the grab bars. They admitted that they took the risk to transfer the resident by them self. After review of the video recording PSW #109 indicated that the expectation was resident #001 to be reassessed for safe transfer.

A review of the home's policy Mechanical Lifts (LTC), #04-66A, revealed the transferring procedure sit-to stand lift will be used to transfer a resident who is able to follow instructions, is able to partially bear weight, has good body strength, is physically reliable and cooperative. Two team members are required if mechanical lifts are used (sit-to-stand or total lift).

Interview with the Kinesiologist Staff #103 revealed the transfer status of resident #001 was two people side by side but it fluctuates and they have to be assessed on everyday basis. Staff #103 indicated if staff evaluates that the resident does not fulfill the criteria for side by side two people transfer they can always go one level up, which is sit-to stand lift or further to total mechanical lift whichever is safer for the resident. If it happens that the

resident is consecutively transferred with a higher level than described in the written plan of care then they have to be re-assessed. During the review of resident #001's video recording with staff #109, they confirmed that the sit-to stand transfer was not appropriate method for resident #001, and that the sit-stand lift should always have two staff according to the policy. Staff #103 further indicated that staff should have sent a referral for resident #001 to be reassessed for safe transfer.

A review of the resident #001's video recording from an identified date, and interview with the General Manager (GM), and also a review of the home's investigation report, confirmed that PSW #112 transferred the resident alone instead of with two staff, from the bed to the wheelchair, contrary to the written plan of care.

A review of the video recordings, the home's transfer policy, interview with Staff #103 and PSW #109, and the home's investigation record confirmed that resident #001 was not transferred safely in several occasions during a specified period and is at risk of imminent injury. [s. 36.]

Additional Required Actions:

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

Issued on this 28th day of March, 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) :	SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2018_631210_0005
Log No. / No de registre :	003841-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 23, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Erin Meadows 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anneliese Krueger

To Schlegel Villages 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg 79.10, s. 36.
Specifically the licensee shall ensure that:
a) Direct care staff (PSWs and Registered staff) use safe transferring and positioning devices or techniques, at all times, when assisting resident #001.
b) If the resident's health status changes and staff have to use a higher level of transfer (sit-to stand or total mechanical lift) the resident is to be reassessed by the interdisciplinary team for the appropriate transfer method or mechanical lifts.
c) If a mechanical lift is to be used for transfer, ensure staff follow the home's policy for two staff actively participating during the transfer.
d) Develop and implement a monitoring tool for documenting the performed transfers during each shift until the compliance date.

Grounds / Motifs :

1. 1. The licence failed to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

MOHLTC received complaints on identified dates, from resident #001's family member that the resident has sustained several injuries of unknown cause, their personal item was damaged several times and staff transferred the resident unsafely.

During an interview with resident #001's family members they shared with the inspector that they have witnessed on several occasions in a specified period that resident #001 gets transferred during activities of daily (ADL) living, by one staff only or some staff uses the sit-stand lift with one staff only.

A review of resident #001's written plan of care revealed that because of poor

balance, unsteadiness, risk of falls, cognitive impairment the transferring status required extensive assistance from two team members without the use of a mechanical device. The resident required extensive assistance from two team members for toileting and related care.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 26, 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 23rd day of March, 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 : Slavica Vucko

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