Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie 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
Aug 22, 2019	2019_715672_0008	005007-18, 007646-18, 022025-18, 023059-18, 032386-18, 032662-18, 033179-18	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 Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

JENNIFER BATTEN (672), KARYN WOOD (601)

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): July 10-12, 15-19, 22-25, 2019

The following intakes were inspected during this inspection:

Log #033179-18 - related to a Critical Incident Report regarding a resident fall resulting in injury for which the resident was taken to hospital

Log #032386-18 - related to a complaint regarding the above resident fall resulting in injury for which the resident was taken to hospital

Log #032662-18 - related to a complaint regarding the above resident fall resulting in injury for which the resident was taken to hospital

Log #007646-18 - related to a complaint regarding withholding of admission to the Long Term Care Home

Log #005007-18 - related to a complaint regarding an allegation of staff to resident abuse

Log #022025-18 - related to a Critical Incident Report regarding an unexpected death of a resident

Log #023059-18 - related to the unexpected death of a resident and an allegation of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, General Manager, Director of Care (DOC), Neighborhood Coordinators (NC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Kinesiologists (Kin), Physiotherapists (PT), Occupational Therapists (OT), Environmental Support Workers (ESW), Environmental Services Manager (ESM), Dietary Services Manager (DSM), residents, family members and visitors to the home.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Falls Prevention
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #004 with a transfer device.

Related to Logs #033179-18, #032386-18 and 032662-18:

A Critical Incident Report was submitted to the Director on a specified date, related to a fall sustained by resident #004 from a transfer device, and resulted in the resident being transferred to the hospital where they received an intervention for a specified injury.

A complaint was received by the Director from one of resident #004's SDMs, related to how resident #004's fall occurred and the way the licensee dealt with the internal investigation into the fall. A second complaint was received by the Director from another SDM of resident #004, related to how resident #004's fall occurred and staff education in the home regarding safe lifting and transferring of residents.

During a telephone interview, one of the complainants indicated to Inspector #672 that they were concerned with the practices of the nursing staff in the home, regarding lifting and transfers of residents. They indicated that they did not believe the nursing staff were following the internal policies related to safe lifting and transfers of residents, specific to the usage of transfer slings and a specified transfer device. Resident #004's SDM alleged they were informed by the nursing staff immediately following resident #004's fall from the transfer device that the transfer sling had not been attached properly to the device, which resulted in the resident falling. Resident #004's SDM further indicated they had been informed that the sling had been positioned under the resident by the staff on the previous shift who had provided personal care to resident #004, which resulted in the sling being left under resident #004 for an extended period of time prior to the actual transfer occurring. Resident #004's SDM stated that upon further questioning, the LTCH staff indicated it was a routine practice of the nursing staff to leave transfer slings under residents for extended periods of time prior to the transfers occurring, which the SDM believed was against the internal policies and procedures of the home.

Review of resident #004's written plan of care indicated the resident required a specified number of staff members to assist with all transfers utilizing the transfer device with a specified transfer sling.

Inspector #672 reviewed the internal investigation notes into resident #004's fall which indicated that resident #004 had been assisted with a transfer via the transfer device by PSWs #104 and #105. Once the resident had been lifted from the surface via the transfer device, PSW #104 observed resident #004 sliding from the sling, which resulted in the PSW letting go of the resident's limb and attempted to support the resident's upper body to prevent the resident from falling from the sling. PSW #104 then "suddenly heard a loud bang" and found that resident #004 was hanging from the sling attached to the

transfer device by their legs. PSWs #104 and #105 immediately assisted resident #004 back to the original surface and observed a specified injury to resident #004. PSWs #104 and #105 called the RN to resident #004's room, who assessed the specified injury and transferred resident #004 to the hospital for further assessment. Resident #004 received an intervention while in the hospital, and was then transferred back to the long term care home on the same day. The internal investigation package also included a document entitled "Investigative Summary from Incident", which outlined what the licensee believed had occurred during the transfer, which was the same information which had been listed in the critical incident report to the Director. The summary also stated that after reviewing the incident and the internal policy/procedures specific to lift and transfers, the licensee determined that the two PSWs involved were following the transfer policy and technique properly.

Inspector #672 reviewed the "Owner's Operator and Maintenance Manual" for the transfer device utilized in resident #004's transfer along with a specified internal policy, which provided specific instructions and directions to the staff regarding how to ensure the transfer sling was correctly attached to the transfer device, how the resident should be positioned when utilizing the transfer device, when/how staff were to check to ensure the resident was positioned correctly in the transfer sling, that two staff members were required for each resident transfer and what each staff member's role was during the transfer. The documents also provided a warning about injuries or damages which may occur if the sling was not properly assessed and connected to the transfer device and stated the sling should not be kept in position under the resident except during the actual transfer unless approval had been given by the Kinesiologist/exercise therapist and the neighborhood specific registered team lead, and was also indicated on the resident's plan of care.

During an interview, PSW #104 indicated that during the transfer of resident #004, they were allocated to the assistant role and PSW #105 operated in the leader role for the procedure. Upon entering resident #004's bedroom that morning, PSWs #104 and #105 found the resident already had the transfer sling positioned under them by the staff on the previous shift, as the staff had provided personal care for resident #004 more than two hours prior to the transfer. PSW #104 indicated that it was a common and accepted practice in the home for one staff member to provide personal care, position a transfer sling under the resident, then move on to provide personal care to the next resident without utilizing the transfer sling to complete the transfer, until personal care had been provided to all of the residents on the resident home area. PSW #104 indicated this practice could lead to residents having a transfer sling positioned under them for

approximately one to two hours at a time. PSW #104 stated that resident #004 required the assistance of a specified number of staff to provide personal care and apply the transfer sling and another specified number of staff to complete the physical transfer via the transfer device. PSW #104 indicated that during resident #004's transfer on the identified date of the fall, PSW #104 was positioned at resident #004's feet, not at the resident's head and shoulders as directed in the internal policy, and PSW #105 was positioned away from the surface behind the transfer device. PSW #104 further indicated that immediately prior to the transfer, PSWs #104 and #105 verbally communicated what colour of loop from the transfer sling they wanted to attach to the transfer device but did not visually or physically check that all hooks and attachments were secured to the transfer device prior to the transfer, as indicated in the internal policy. PSW #104 indicated that once they believed the transfer sling was attached to the transfer device, PSW #105 raised resident #004 off of the surface and transferred them without pausing to allow the resident time to adjust or for staff to provide adjustments for the resident, if necessary; to ensure the resident felt safe and secure; or to assess if the resident was off balance in the transfer sling. Resident #004 was transferred on a horizontal angle while PSW #104 supported the resident's legs and feet, and was not turned to face the mast of the lift while still above the surface prior to the transfer, as directed in the internal policy.

During separate interviews, PSWs #109, #114 and #122 indicated it was a common and accepted practice in the home for one staff member to provide personal care, position a transfer sling under the resident, then move on to provide personal care to the next resident without utilizing the transfer sling to complete the transfer, until personal care had been provided to all of the residents on the resident home area. The PSWs further indicated this practice was implemented in an attempt to save time, as it was easier to complete all resident transfers at once, when both staff members and the transfer device were available, instead of one staff member having to wait for another staff member or the transfer device to become available.

During an interview on a specified date, the Kinesiologist indicated that it was an acceptable practice in the home for staff to place a transfer sling under a resident after care had been provided, leave the resident for a period of time to provide care to other residents, and then return to get the resident up at a later point. The Kinesiologist further indicated the expectation in the home was for staff to check the placement of the sling under the resident prior to beginning the transfer in the transfer device to ensure the transfer sling remained in the proper position. If the transfer sling was found to have shifted, the staff were expected to reposition the sling prior to transferring the resident

from the surface. The Kinesiologist indicated it was not an expectation that the staff follow the internal policy related to the transfer device from procedural step one to the final step listed in the policy, as there were no adverse effects on the resident if the sling was left under them, and this practice assisted the front line staff with time management. Lastly, the Kinesiologist indicated that it would only be listed in a resident's plan of care that the sling could remain under them if the sling was present under the resident at all times, not just while waiting to be transferred.

During a follow up interview on a later specified date, Inspector #672 reviewed the internal policy related to the transfer device with the Kinesiologist. The Kinesiologist indicated that they had misunderstood some of the questions during the initial interview, and the expectation in the home was for two staff members to position a transfer sling under the resident, then conduct the transfer. The Kinesiologist further indicated it was not an acceptable practice in the home to leave a transfer sling under a resident, then go on to assist other residents with personal care, and complete all of the resident transfers via the transfer device after care had been provided, as that practice was not safe for residents and went against the directions provided to staff in the internal policy.

During an interview, the Administrator indicated it was an expectation in the home for staff to follow all internal policies and procedures, including the internal safe lift and transfer policy related to the transfer device.

The licensee failed to ensure that PSWs #104 and #105 adhered to the internal policy related to the transfer device and used safe transferring and positioning techniques when assisting resident #004 during a transfer with the transfer device. As a result, the resident sustained an identified injury which required the resident to be transferred to the hospital and receive an identified intervention. [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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASDs which were used to assist residents #004, #008 and #009 with routine activities of daily living were included in the residents' plan of care.

Related to Logs #033179-18, #032386-18 and 032662-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004 from the transfer device on a specified date. Resident #004's fall resulted in a transfer to hospital where the resident received an intervention related to an identified injury.

A complaint was received by the Director on a specified date, from one of resident #004's SDMs, related to how resident #004's fall occurred and the process of how the licensee dealt with the internal investigation into the fall. A second complaint was then received by the Director on another specified date, from another SDM of resident #004, related to how resident #004's fall occurred and staff education in the home regarding safe lifting and transferring of residents.

During a resident observation, Inspector #672 observed resident #004 seated in the resident home area lounge in a specified mobility aid which was in an identified position with another safety intervention in place. Inspector #672 then made further resident observations of resident #004 on seven separate occasions. During each of the resident observations, Inspector #672 observed resident #004 to be in a specified mobility aid which was in an identified position with another safety intervention in place.

During separate interviews, PSWs #104, #114 and #122 indicated that resident #004 utilized a specified mobility aid which was in an identified position with another safety intervention in place at all times when resident #004 utilized the specified mobility aid, except when meals were consumed. PSWs #104 and #114 further indicated that resident #004 utilized the identified safety intervention and position while in the specified mobility aid as a PASD for repositioning and falls prevention purposes, in an attempt to ensure the resident remained comfortable at all times and for falls prevention purposes.

During an interview, RPN #115 verified the information PSWs #104, #114 and #122 provided. RPN #115 indicated the identified safety intervention and position while in the specified mobility aid utilized by resident #004 was for repositioning and falls prevention purposes and was considered to be a PASD. RPN #115 further indicated the expectation in the home was that whenever a resident utilized a PASD to assist with routine activities of living, the PASD was to be included in the resident's plan of care.

Inspector #672 reviewed the licensee's internal policy related to restraints and PASDs, which stated residents may only use restraints and PASDs in the home if the device was included in the resident's plan of care. The internal policy also included specified instructions related to their usage.

Inspector #672 reviewed resident #004's plan of care and observed that it did not include information regarding the PASD related to the identified safety intervention and position while in the specified mobility aid. Inspector #672 then reviewed resident #004's plan of care with RPN #115, who verified the information related to the PASDs used to assist resident #004 with routine activities of living had not been included in the resident's plan of care.

Inspector #672 then expanded the scope of assessment to include two more residents who utilized PASDs within the home, to assess if the PASDs used to assist with routine activities of living had been included in the resident's plan of care. On a specified date, Inspector #672 observed two residents in identified mobility aids in a specified position in resident #004's home area lounge and was provided with the names of residents #008 and #009 from PSW #122, who indicated both residents utilized the identified mobility aids in the specified position within the home for PASD purposes.

Related to resident #008:

During an interview, PSW #122 indicated resident #008 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #008 was utilizing the mobility aid, except when meals were consumed. PSW #122 further indicated that resident #008 utilized the identified mobility aid in the specified position as a PASD for the purposes of repositioning, comfort and falls prevention, in an attempt to ensure the resident remained in a comfortable position at all times and did not fall.

Related to resident #009:

During an interview, PSW #122 indicated resident #009 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #009 was utilizing the mobility aid, except when meals were consumed. PSW #122 further indicated that resident #009 utilized the specified position while utilizing the identified mobility aid as a PASD for repositioning, comfort and falls prevention purposes, in an attempt to ensure the resident remained comfortable at all times and did not attempt to self transfer, as they were at increased risk for falling.

During an interview, RPN #115 indicated resident #008 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #008 was utilizing the mobility aid, except when meals were consumed for PASD purposes, related to

positioning and comfort. RPN #115 further indicated the expectation in the home was that any resident who had a PASD in place, such as resident #008's identified mobility aid, should have the PASD listed within the resident's plan of care. Related to resident #009, RPN #115 indicated the resident utilized an identified mobility aid which was to be kept in a specified position for PASD purposes, related to repositioning and comfort, along with restraint purposes related to attempting to prevent the resident from self transferring, as the resident was at high risk for falls. RPN #115 further indicated the expectation in the home was that any resident who had a restraint in place, such as resident #009's identified mobility aid, should be listed within the resident's plan of care.

Inspector #672 then reviewed resident #008 and #009's plan of care with RPN #115 and did not observe any mention of either resident's identified mobility aids, instructions that the identified mobility aids were to be kept in a specified position at all times except when meals were consumed, or that the specified positioning of the mobility aids were implemented for PASD or restraint purposes.

During separate interviews, the RAI Coordinator and DOC indicated the expectation in the home was that whenever a resident utilized a PASD to assist with a routine activity of living, or had a restraint in place, they were both expected to be included in the resident's plan of care. The RAI Coordinator and DOC further indicated that it was the responsibility of the Registered staff on duty to ensure that every resident's plan of care was updated as required and include all PASDs and restraints utilized by the resident.

The licensee failed to ensure that the PASDs which were used to assist residents #004, #008 and #009 with routine activities of daily living were included in the residents' plan of care. [s. 33. (3)]

2. The licensee failed to ensure that PASDs utilized by residents #004, #008 and #009 had been approved by any person provided for in the regulations prior to usage.

Related to Logs #033179-18, #032386-18 and 032662-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004 from the transfer device on a specified date. Resident #004's fall resulted in a transfer to hospital where the resident received an intervention related to an identified injury.

A complaint was received by the Director on a specified date, from one of resident #004's SDMs, related to how resident #004's fall occurred and the process of how the licensee dealt with the internal investigation into the fall. A second complaint was then received by the Director on another specified date, from another SDM of resident #004, related to how resident #004's fall occurred and staff education in the home regarding safe lifting and transferring of residents.

During a resident observation, Inspector #672 observed resident #004 seated in the resident home area lounge in a specified mobility aid which was in an identified position with another safety intervention in place. Inspector #672 then made further resident observations of resident #004 on seven separate occasions. During each of the resident observations, Inspector #672 observed resident #004 to be in a specified mobility aid which was in an identified position with another safety intervention in place.

During separate interviews, PSWs #104, #114 and #122 indicated that resident #004 utilized a specified mobility aid which was in an identified position with another safety intervention in place at all times when resident #004 utilized the specified mobility aid, except when meals were consumed. PSWs #104 and #114 further indicated that resident #004 utilized the identified safety intervention and position while in the specified mobility aid as a PASD for repositioning and falls prevention purposes, in an attempt to ensure the resident remained comfortable at all times and for falls prevention purposes.

During an interview, RPN #115 verified the information PSWs #104, #114 and #122 provided. RPN #115 indicated the identified safety intervention and identified position while utilizing the specified mobility aid by resident #004 was for repositioning and falls prevention purposes and was considered to be a PASD. RPN #115 further indicated the expectation in the home was that whenever a resident utilized a PASD to assist with routine activities of living, the PASD was to be approved by the physician and an order provided prior to usage.

Inspector #672 reviewed the licensee's internal policy related to restraints and PASDs, which stated residents may only use restraints and PASDs in the home if the device was approved by specified professionals in the home and an order for the usage of the device was in place, which was to be reviewed at a minimum of every three months, to ensure the PASD and/or restraint still required by the resident.

Inspector #672 reviewed resident #004's health care record and observed that it did not include an approval by any professional listed within the legislation, regarding the PASD

related to the specified mobility aid which was in an identified position, or the other safety intervention which was observed to be in place. Inspector #672 then reviewed resident #004's health care record with RPN #115, who verified there was not an approval documented by any professional listed within the legislation, related to the PASDs used to assist resident #004 with routine activities of living.

Inspector #672 then expanded the scope of assessment to include two more residents who utilized PASDs within the home, to assess if the PASDs used to assist with routine activities of living had been approved by any professional listed within the legislation. On a specified date, Inspector #672 observed two residents in identified mobility aids in a specified position in resident #004's home area lounge and was provided with the names of residents #008 and #009 from PSW #122, who indicated both residents utilized the identified mobility aids in the specified position within the home for PASD purposes.

Related to resident #008:

During an interview, PSW #122 indicated resident #008 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #008 was utilizing the mobility aid, except when meals were consumed. PSW #122 further indicated that resident #008 utilized the identified mobility aid in the specified position as a PASD for the purposes of repositioning, comfort and falls prevention, in an attempt to ensure the resident remained in a comfortable position at all times and did not fall.

Related to resident #009:

During an interview, PSW #122 indicated resident #009 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #009 was utilizing the mobility aid, except when meals were consumed. PSW #122 further indicated that resident #009 utilized the specified position while utilizing the identified mobility aid as a PASD for repositioning, comfort and falls prevention purposes, in an attempt to ensure the resident remained comfortable at all times and did not attempt to self transfer, as they were at increased risk for falling.

During an interview, RPN #115 verified the information PSWs #104, #114 and #122 provided. RPN #115 indicated the identified safety intervention and position while in the specified mobility aid utilized by resident #004 was for repositioning and falls prevention purposes and was considered to be a PASD. RPN #115 further indicated the expectation in the home was that whenever a resident utilized a PASD to assist with routine activities

of living, such as resident #008's specified mobility aid, there should be a physician's order in place. Related to resident #009, RPN #115 indicated the resident utilized an identified mobility aid which was to be kept in a specified position for PASD purposes, related to repositioning and comfort, along with restraint purposes related to attempting to prevent the resident from self transferring, as the resident was at high risk for falls. RPN #115 further indicated the expectation in the home was that any resident who had a restraint in place, such as resident #009's identified mobility aid utilized in the specified position, should have a physician's order in place.

Inspector #672 then reviewed resident #008 and #009's health care record with RPN #115 and did not observe any documented approval by the physician or any other professional listed within the legislation, related to resident #008 or #009's identified mobility aids utilized in a specified position which were to be implemented for PASD and/or restraint purposes.

During separate interviews, the RAI Coordinator and DOC indicated the expectation in the home was that whenever a resident utilized a PASD to assist with a routine activity of living, or had a restraint in place, a physician's order was required.

The licensee failed to ensure that residents #004, #008 and #009's PASDs had been approved by any person provided for in the regulations. [s. 33. (4) 3.]

3. The licensee failed to ensure that consent had been received from resident #004, #008 and #009's SDM prior to the usage of the PASD.

Related to Logs #033179-18, #032386-18 and 032662-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004 from the transfer device on a specified date. Resident #004's fall resulted in a transfer to hospital where the resident received an intervention related to an identified injury.

A complaint was received by the Director on a specified date, from one of resident #004's SDMs, related to how resident #004's fall occurred and the process of how the licensee dealt with the internal investigation into the fall. A second complaint was then received by the Director on another specified date, from another SDM of resident #004, related to how resident #004's fall occurred and staff education in the home regarding safe lifting and transferring of residents.

During a resident observation, Inspector #672 observed resident #004 seated in the resident home area lounge in a specified mobility aid which was in an identified position with another safety intervention in place. Inspector #672 then made further resident observations of resident #004 on seven separate occasions. During each of the resident observations, Inspector #672 observed resident #004 to be in a specified mobility aid which was in an identified position with another safety intervention in place.

During separate interviews, PSWs #104, #114 and #122 indicated that resident #004 utilized a specified mobility aid which was in an identified position with another safety intervention in place at all times when resident #004 utilized the specified mobility aid, except when meals were consumed. PSWs #104 and #114 further indicated that resident #004 utilized the identified safety intervention and position while in the specified mobility aid as a PASD for repositioning and falls prevention purposes, in an attempt to ensure the resident remained comfortable at all times and for falls prevention purposes.

During an interview, RPN #115 verified the information PSWs #104, #114 and #122 provided. RPN #115 indicated the identified safety intervention and identified position while utilizing the specified mobility aid by resident #004 was for repositioning and falls prevention purposes and was considered to be a PASD. RPN #115 further indicated the expectation in the home was that whenever a resident utilized a PASD to assist with routine activities of living, consent from the resident and/or the SDM was required.

Inspector #672 reviewed the licensee's internal policy related to restraints and PASDs, which stated residents may only use restraints and PASDs in the home if the usage of the device had been consented to by the resident and/or the resident's SDM. Consent to the usage of restraints and PASDs in the home could only be provided by the resident and/or the SDM after education had been provided to them on the device and they were informed of the process.

Inspector #672 reviewed resident #004's health care record and observed that resident #004 had an identified CPS score which indicated they would have required signed consent for the usage of the PASD from their SDM. Inspector #672 continued to review resident #004's health care record and observed it did not include any documentation or signed consent forms from the SDM regarding usage of the PASD specific to the identified safety intervention and identified position while utilizing the specified mobility aid. Inspector #672 then reviewed resident #004's health care record with RPN #115, who verified there was not any documentation or signed consent forms from resident

#004's SDM, related to the PASDs used to assist the resident with routine activities of living.

Inspector #672 then expanded the scope of assessment to include two more residents who utilized PASDs within the home, to assess if the PASDs used to assist with routine activities of living had been consented to by the resident and/or the resident's SDM. On a specified date, Inspector #672 observed two residents in identified mobility aids in a specified position in resident #004's home area lounge and was provided with the names of residents #008 and #009 from PSW #122, who indicated both residents utilized the identified mobility aids in the specified position within the home for PASD purposes.

Related to resident #008:

During an interview, PSW #122 indicated resident #008 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #008 was utilizing the mobility aid, except when meals were consumed. PSW #122 further indicated that resident #008 utilized the identified mobility aid in the specified position as a PASD for the purposes of repositioning, comfort and falls prevention, in an attempt to ensure the resident remained in a comfortable position at all times and did not fall.

Related to resident #009:

During an interview, PSW #122 indicated resident #009 utilized an identified mobility aid which was to be kept in a specified position at all times when resident #009 was utilizing the mobility aid, except when meals were consumed. PSW #122 further indicated that resident #009 utilized the specified position while using the identified mobility aid as a PASD for repositioning, comfort and falls prevention.

During an interview, RPN #115 verified the information PSWs #104, #114 and #122 provided. RPN #115 indicated the identified safety intervention and position while in the specified mobility aid utilized by resident #004 was for repositioning and falls prevention purposes and was considered to be a PASD. RPN #115 further indicated the expectation in the home was that whenever a resident utilized a PASD to assist with routine activities of living, such as resident #008's specified mobility aid, there should be a documented consent from the resident and/or the SDM in place, prior to usage. Related to resident #009, RPN #115 indicated the resident utilized an identified mobility aid which was to be kept in a specified position for PASD purposes for repositioning and comfort, as well as for restraint purposes to prevent self transfers. RPN #115 further indicated the

expectation in the home was that any resident who had a restraint in place, such as resident #009's identified mobility aid utilized in the specified position, should have documented consent from the resident and/or the SDM in place, prior to usage.

Inspector #672 reviewed resident #008's health care record and observed that resident #008 had an identified CPS score which indicated they would have required signed consent for the usage of the PASD from their SDM. Inspector #672 continued to review resident #008's health care record and observed it did not include any documentation or signed consent forms from the SDM regarding usage of the PASD specific to the identified mobility aid which was to be kept in a specified position.

Inspector #672 then reviewed resident #009's health care record and observed that resident #009 had an identified CPS score which indicated they would have required signed consent for the usage of the PASD from their SDM. Inspector #672 continued to review resident #009's health care record and observed it did not include any documentation or signed consent forms from the SDM regarding usage of the PASD/restraint specific to the identified mobility aid which was to be kept in a specified position.

Inspector #672 reviewed resident #008 and #009's health care record with RPN #115 and did not observe any documented consent from either resident's SDM related to usage of the identified mobility aid which were to be kept in a specified position for PASD and/or restraint purposes.

During separate interviews, the RAI Coordinator and DOC indicated the expectation in the home was that whenever a resident utilized a PASD to assist with a routine activity of living, or had a restraint in place, resident and/or SDM consent was required prior to usage.

The licensee failed to ensure the PASDs utilized by residents #004, #008 and #009 and a restraint utilized to assist resident #009 with routine activities of living had been consented to by the resident and/or the SDM prior to usage. [s. 33. (4) 4.]

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 all PASDs are included in the residents' plan of care, have consent from the resident/SDM and are approved by any person provided for in the regulations prior to usage, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had their personal items such as hairbrushes and deodorant labelled.

During resident observations on a specified date and time, Inspector #672 observed the Spa room door on an identified resident home area was left open. Upon closer inspection, Inspector #672 observed unlabelled personal items which appeared to have been previously used sitting on the countertop.

During separate interviews, PSWs #108 and #109 indicated they were unsure of who the opened and unlabelled personal items belonged to. PSW #109 further indicated that one of the unlabelled personal items may have been left in the Spa room for usage if staff forgot to bring a resident's personal item with them to the tub room in preparation for the bath/shower. PSWs #108 and #109 further indicated the expectation in the home was for every resident to have their own, labelled personal care items.

During resident observations on a specified date and time on another identified resident home area, Inspector #672 observed the Spa room door propped open. Upon closer inspection, Inspector #672 observed a number of unlabelled personal items in the spa area.

During an interview, PSW #111 indicated they were unable to indicate who the unlabelled items in the Spa room belonged to. PSW #111 further indicated some of the unlabelled personal items were sometimes used for residents following their bath/shower, if the staff member forgot to bring the resident's own supplies with them to the Spa room, or if the resident didn't have their own. PSW #111 further indicated the expectation in the home was for every resident to have their own labelled personal care items.

During an interview, RPN #110 indicated they believed they were aware of who an unlabelled electric razor belonged to, but would follow up to be sure, and then label the electric razor with the resident's name. RPN #110 further indicated the expectation in the home was for every resident to have each of their personal care items labelled with their names, and for the items to only be used for that resident.

During resident observations on a specified date and time on a third identified resident home area, Inspector #672 observed the Spa room door propped open, with a wet floor sign at the doorway. Staff indicated the door had been left open in an attempt to assist with the floor drying at a faster pace. Upon closer inspection, Inspector #672 observed an unlabelled personal care item sitting on a shelf in the spa room.

During an interview, PSW #121 indicated they could not state who the unlabelled personal care item belonged to. PSW #121 further indicated the expectation in the home was for each resident to have their own labelled personal care items brought to the Spa room for usage following their shower or bath. PSW #121 indicated unlabelled items should not be used on residents and would ensure the item was immediately disposed of, since they were unaware of who it belonged to.

During an interview, the DOC indicated the expectation in the home was for every resident to have their personal care items labelled with the resident's name. The DOC further indicated it was not an acceptable practice for staff to utilize personal care items or products for multiple residents, and if a staff member forgot to bring a needed item to the Spa room for the resident's bath/shower, the expectation in the home was for the staff member to return to the resident's room to secure the item.

The licensee failed to ensure that every resident had their personal care items labelled with the resident's name. [s. 37. (1) (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 every resident has their personal items such as hairbrushes and deodorant labelled, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

During resident observations on a specified date and time, Inspector #672 entered the elevator which led to two resident home areas and found an unattended cleaning cart along with a cart that the resident's labeling machine was stored on, with no staff members observed to be in the immediate area outside of the elevator. Inspector #672 observed the cleaning cart had a cage attached to it, with a padlock, and the cleaning chemicals were stored within. Upon closer inspection, Inspector #672 observed that the padlock was not attached to the locking mechanism, and the lid to the cage could be easily lifted and accessed the cleaning chemicals. Prior to entering the elevator to find the cleaning cart, Inspector #672 had observed the elevator be used twice while the cleaning cart was present and unattended. The first time the elevator was utilized by a resident and a family member, and the second time the elevator was utilized by an unescorted resident. Inspector #672 removed the unattended cleaning cart from the elevator and waited for the staff member responsible for the cleaning cart to return.

At a later identified time, eleven minutes after Inspector #672 removed the cleaning cart

from the elevator, Environmental Support Worker (ESW) #128 arrived and indicated they were responsible for the cleaning and labelling carts left unattended on the elevator. ESW #128 further indicated they were unsure of how long they had left the carts unattended on the elevator for, as they had gotten distracted by engaging in conversation with staff from one of the resident home areas. ESW #128 indicated the expectation in the home was that cleaning chemicals were to be stored in the locked cage on the cleaning carts at all times when not in use with the padlock secured appropriately, and the cart should not have been left unattended on the elevator. ESW #128 indicated the cleaning chemicals were required to be kept inaccessible to residents at all times due to the hazardous nature of the chemicals and stated the chemicals could be dangerous for a resident, if accessed.

During resident observations on a specified date and time, Inspector #672 observed the Spa room door on an identified resident home area was left open. Upon closer inspection, Inspector #672 observed three unattended potentially hazardous substances.

During separate interviews, PSW #108 and #109 indicated that Spa room doors were expected to remain closed and locked at all times when not in use. PSW #109 indicated they had forgotten to close the Spa room door after they had finished providing a resident shower, approximately 20-30 minutes prior to the observation.

During an interview, the Environmental Services Manager (ESM) indicated the expectation in the home was that cleaning chemicals were to be kept stored and locked in the cage on the cleaning carts at all times when not in use, and the carts should not be left unattended on an elevator. The ESM further indicated that the cleaning chemicals were required to be kept inaccessible to residents at all times as they could be hazardous to resident's safety, and would follow up with ESW #128.

During an interview, the DOC indicated the expectation in the home was for all Spa room doors to be kept closed and locked at all times when not in use.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times, when potentially hazardous substances were identified in an unattended and open cleaning cart left on an elevator which was utilized by residents and visitors to the home for a minimum of eleven minutes, and in a Spa room which had been left open and unattended for approximately 20 to 30 minutes. [s. 91.]

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 all hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after an incident occurred that caused an injury to resident #004 which resulted in the resident being taken to a hospital and a significant change in the resident's health condition.

Related to Log # 033179-18:

A Critical Incident Report was submitted to the Director on a specified date, related to a fall sustained by resident #004 eleven days prior, from a transfer device, and resulted in the resident being transferred to the hospital where they received an intervention for a specified injury.

Related to Log #032662-18 and #032386-18:

Two separate complaints were received by the Director on two specified dates from two of resident #004's family members, related to concerns regarding resident #004's fall from the transfer device.

During a telephone interview, one of the complainants indicated that a meeting with the nursing management team had occurred in the LTCH eleven days after the fall occurred, to review their concerns regarding the incident when resident #004 fell from the transfer device. The complainant further indicated that during the meeting, they had requested the Director be notified of the incident, as the nursing management team at the LTCH had not informed the Director of resident #004's fall from the transfer device, subsequent injury and transfer to hospital.

During an interview, the DOC indicated they had not informed the Director following resident #004's fall from the transfer device, as they did not believe the fall had resulted in a significant change to resident #004's health status. Inspector #672 reviewed the definition of significant change listed within the legislation with the DOC, which stated the following:

"Significant change means a major change in the resident's health condition that,
(a) Will not resolve itself without further intervention"

During the interview, the DOC indicated that resident #004 was transferred to hospital following the incident and received a specified intervention to the identified injury, which may not have resolved itself without the interventions provided to the resident in the hospital. The DOC further indicated they were aware of the legislative requirements which instructed that the Director be notified within one business day if an incident occurred that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

The licensee failed to ensure that when resident #004 fell from the transfer device and sustained an identified injury resulting in the resident being transferred to hospital and receiving a specified intervention, without which the identified injury may not have resolved, that the Director was notified within one business day. The Director was not notified of the incident until seven business days after the incident occurred, when the licensee received a complaint from resident #004's SDM, which specifically requested for the Director to be notified. [s. 107. (3) 4.]

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 the Director is informed of all critical incidents directed within the regulations within the specified time periods, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that medications were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies which was kept secured and locked.

During resident observations on a specified date and time, Inspector #672 observed the Spa room door on an identified resident home area was left open. Upon closer inspection, Inspector #672 observed a care caddie sitting on top of a linen cart in the Spa room which was filled with fifteen medicated creams belonging to residents who resided on the resident home area, along with two sharps containers partially filled with used sharps instruments.

During separate interviews, PSW #108 and #109 indicated that Spa room doors were expected to remain closed and locked at all times when not in use. PSW #109 indicated they had forgotten to close the Spa room door after they had finished providing a resident shower. In relation to the medicated creams, PSWs #108 and #109 indicated the PSW staff would receive resident's medicated creams at the beginning of each shift, and would store them in the Spa room for usage throughout the shift. At the end of each shift the medicated creams were expected to be returned to the RPN, so they could be locked in the Medication Room until the next time they were required.

During resident observations on a specified date and time, Inspector #672 observed two care caddies sitting on top of a desk at the nursing station in another identified resident home area, across from the resident lounge area. At the time of the observation there were four residents sitting in the resident lounge area watching TV, with no staff members observed to be in the immediate area. The two care caddies on the nursing desk contained 22 medicated creams which belonged to residents who resided on the resident home area.

During an interview, RPN #110 indicated the expectation in the home was for all medicated creams to be kept in the locked medication room when not in use. RPN #110 further indicated the medicated creams had been placed on the desk of the nursing station after they were returned by the PSW staff following application during morning care and verified the medicated creams had been left in an area which was accessible to residents when no staff members were in the immediate area.

During resident observations on a specified date and time, Inspector #672 observed the Spa room door on a third identified resident home area was left open. Upon closer inspection, Inspector #672 observed a care caddie sitting on top of a linen cart in the Spa room which was filled with twelve medicated creams which belonged to residents who resided on the resident home area.

During an interview, PSW #121 indicated the expectation in the home was for the Spa room doors to remain closed and locked at all times when not in use. PSW #121 further indicated the Spa room door had been left open after the floor of the Spa room had been washed, to assist with the floor drying in a faster manner. PSW #121 indicated the medicated creams had been provided to the PSW staff at the beginning of the shift by the RPN, and the medicated creams would be stored in the Spa room for easy access throughout the shift. At the end of the shift the medicated creams would then be returned

to the RPN, so that they could be returned to the locked medication room.

During resident observations on a specified date and time, Inspector #672 observed the medication room door on an identified resident home area to be left propped wide open. Inspector approached the room looking for the RPN, but no staff were observed in the immediate area. Inspector #672 then observed that the medication cart had also been left unlocked and was able to open each of the drawers on the medication cart, accessing the medications for every resident who resided on the resident home area. Approximately three minutes after entering the medication room, RPN #110 arrived, and locked the medication cart.

During an interview, RPN #110 indicated the expectation in the home was for the medication room door and the medication cart to be kept closed and locked at all times when not in use.

During an interview, the DOC indicated the expectation in the home was for all Spa and Medication room doors to be kept closed and locked at all times when not in use. The DOC further indicated the expectation in the home was for medicated creams to be provided to the PSW staff as the creams were required for application on the residents. The medicated creams were then to be immediately returned to the registered staff following usage, and stored in the locked medication room, not kept in the Spa rooms throughout the shifts.

The licensee failed to ensure that medicated creams were stored in an area or medication cart that was kept secured and locked and used exclusively for drugs and drug-related supplies, when medicated creams were observed on two occasions to have been left in an open Spa room and on the desk of a nursing station on another occasion during a three day time span. The licensee also failed to ensure that all medications were stored in a secured and locked area, when the medication room door and medication cart were left open and unlocked on the Claremont resident home area, with no staff present in the immediate area. [s. 129. (1) (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 medications are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies that is kept secured and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Related to Log #007646-18:

A complaint was received by the Director indicating an applicant had been refused admission to the Long-Term Care Home.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission because the home lacked the physical facilities to support the applicant's care requirements.

The refusal letter did not provide for any further explanation of how the LTCH lacked the physical facilities to support the applicant's care requirements, and was signed by the previous DOC.

The previous DOC was not available for interview during this inspection.

During an interview, a coordinator from the CELHIN indicated their notes stated the applicant was a patient in a hospital when the application to the LTCH was made. The applicant was refused admission to the LTCH due to the applicant's specialized care needs and had required the use of a specified transfer device. The coordinator from the CELHIN further indicated their notes stated the previous DOC of the LTCH had indicated the applicant's specialized care needs exceeded the parameters the transfer device in the home could safely transfer, therefore the home lacked the physical facilities necessary to support the applicant's care requirements and refused the application. The CELHIN coordinator indicated the applicant passed away in hospital.

During an interview, the RAI Coordinator indicated they were responsible for receiving the applications for the LTCH and had forwarded a copy of the applicant's Placement Services Assessment Tool provided by the CELHIN to the previous DOC of the LTCH, who made the final decisions regarding admission to the LTCH. The RAI Coordinator

indicated they could not recall specific information related to the applicant but did recall the previous DOC had refused admission to an applicant based on the applicant requiring specialized equipment.

During an interview, the current DOC of The Village of Taunton Mills indicated they could not speak to why the previous DOC had declined the application but felt that an applicant requiring specialized equipment would not be an acceptable reason to refuse admission to the home. The DOC further indicated the LTCH could have purchased a specialized transfer device if one had been required to meet the applicant's care needs.

The documented evidence provided by the licensee did not fully explain how the home lacked the physical facilities to support the applicant's care requirements. [s. 44. (7)]

2. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director.

Related to Log #007646-18:

This inspection was initiated related to a complaint received by the Ministry of Health and Long Term Care, submitted by the Central East Local Health Integration Network (CELHIN), related to applicant #006. The complaint pertained to withholding approval for admission to The Village of Taunton Mills LTC Home.

An application for admission was made to the LTC home. A letter from the previous Director of Care on behalf of The Village of Taunton Mills LTC home addressed to the applicant stated the application was denied due to the LTC home not having the physical facilities to support the applicant's care requirements.

During separate interviews, the DOC and the RAI Coordinator indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for

the Director. Following review of the letter addressed to applicant #006, the DOC and RAI Coordinator indicated the letter did not meet the requirements, as it did not provide for a detailed explanation of the supporting facts related both to the home and to the applicant's condition and requirements for care, how the supporting facts justified the decision to withhold approval, or contact information for the Director. [s. 44. (9)]

Issued on this 23rd day of September, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672), KARYN WOOD (601)
Inspection No. / No de l'inspection :	2019_715672_0008
Log No. / No de registre :	005007-18, 007646-18, 022025-18, 023059-18, 032386-18, 032662-18, 033179-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 22, 2019
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 Taunton Mills 3800 Brock Street North, WHITBY, ON, L1R-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Daniel Kennedy

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 Schlegel Villages Inc., 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

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

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 r. 36 of the LTCHA, 2007.

The licensee is ordered to:

1) Educate all front line nursing staff, and any other staff member who may assist in resident transfers utilizing the transfer device on the internal policy related to the transfer device. A documented record of this training must be kept.

2) Create an auditing process and conduct audits one time monthly for a six month period, to ensure staff are following the internal policy, and are not positioning transfer slings under residents until the transfer is ready to be completed in full. A documented record of this audit must be kept.

3) Develop an outline of the corrective actions to be taken and by whom, if staff fail to follow the internal policy related to the transfer device, and keep a documented record.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #004 with a transfer device.

Related to Logs #033179-18, #032386-18 and 032662-18:

A Critical Incident Report was submitted to the Director on a specified date, related to a fall sustained by resident #004 from a transfer device, and resulted in the resident being transferred to the hospital where they received an

intervention for a specified injury.

A complaint was received by the Director from one of resident #004's SDMs, related to how resident #004's fall occurred and the way the licensee dealt with the internal investigation into the fall. A second complaint was received by the Director from another SDM of resident #004, related to how resident #004's fall occurred and staff education in the home regarding safe lifting and transferring of residents.

During a telephone interview, one of the complainants indicated to Inspector #672 that they were concerned with the practices of the nursing staff in the home, regarding lifting and transfers of residents. They indicated that they did not believe the nursing staff were following the internal policies related to safe lifting and transfers of residents, specific to the usage of transfer slings and a specified transfer device. Resident #004's SDM alleged they were informed by the nursing staff immediately following resident #004's fall from the transfer device that the transfer sling had not been attached properly to the device, which resulted in the resident falling. Resident #004's SDM further indicated they had been informed that the sling had been positioned under the resident by the staff on the previous shift who had provided personal care to resident #004, which resulted in the sling being left under resident #004 for an extended period of time prior to the actual transfer occurring. Resident #004's SDM stated that upon further questioning, the LTCH staff indicated it was a routine practice of the nursing staff to leave transfer slings under residents for extended periods of time prior to the transfers occurring, which the SDM believed was against the internal policies and procedures of the home.

Review of resident #004's written plan of care indicated the resident required a specified number of staff members to assist with all transfers utilizing the transfer device with a specified transfer sling.

Inspector #672 reviewed the internal investigation notes into resident #004's fall which indicated that resident #004 had been assisted with a transfer via the transfer device by PSWs #104 and #105. Once the resident had been lifted from the surface via the transfer device, PSW #104 observed resident #004 sliding from the sling, which resulted in the PSW letting go of the resident's limb and attempted to support the resident's upper body to prevent the resident from

falling from the sling. PSW #104 then "suddenly heard a loud bang" and found that resident #004 was hanging from the sling attached to the transfer device by their legs. PSWs #104 and #105 immediately assisted resident #004 back to the original surface and observed a specified injury to resident #004. PSWs #104 and #105 called the RN to resident #004's room, who assessed the specified injury and transferred resident #004 to the hospital for further assessment. Resident #004 received an intervention while in the hospital, and was then transferred back to the long term care home on the same day. The internal investigation package also included a document entitled "Investigative Summary from Incident", which outlined what the licensee believed had occurred during the transfer, which was the same information which had been listed in the critical incident report to the Director. The summary also stated that after reviewing the incident and the internal policy/procedures specific to lift and transfers, the licensee determined that the two PSWs involved were following the transfer policy and technique properly.

Inspector #672 reviewed the "Owner's Operator and Maintenance Manual" for the transfer device utilized in resident #004's transfer along with a specified internal policy, which provided specific instructions and directions to the staff regarding how to ensure the transfer sling was correctly attached to the transfer device, how the resident should be positioned when utilizing the transfer device, when/how staff were to check to ensure the resident was positioned correctly in the transfer sling, that two staff members were required for each resident transfer and what each staff member's role was during the transfer. The documents also provided a warning about injuries or damages which may occur if the sling was not properly assessed and connected to the transfer device and stated the sling should not be kept in position under the resident except during the actual transfer unless approval had been given by the Kinesiologist/exercise therapist and the neighborhood specific registered team lead, and was also indicated on the resident's plan of care.

During an interview, PSW #104 indicated that during the transfer of resident #004, they were allocated to the assistant role and PSW #105 operated in the leader role for the procedure. Upon entering resident #004's bedroom that morning, PSWs #104 and #105 found the resident already had the transfer sling positioned under them by the staff on the previous shift, as the staff had provided personal care for resident #004 more than two hours prior to the

transfer. PSW #104 indicated that it was a common and accepted practice in the home for one staff member to provide personal care, position a transfer sling under the resident, then move on to provide personal care to the next resident without utilizing the transfer sling to complete the transfer, until personal care had been provided to all of the residents on the resident home area. PSW #104 indicated this practice could lead to residents having a transfer sling positioned under them for approximately one to two hours at a time. PSW #104 stated that resident #004 required the assistance of a specified number of staff to provide personal care and apply the transfer sling and another specified number of staff to complete the physical transfer via the transfer device. PSW #104 indicated that during resident #004's transfer on the identified date of the fall, PSW #104 was positioned at resident #004's feet, not at the resident's head and shoulders as directed in the internal policy, and PSW #105 was positioned away from the surface behind the transfer device. PSW #104 further indicated that immediately prior to the transfer, PSWs #104 and #105 verbally communicated what colour of loop from the transfer sling they wanted to attach to the transfer device but did not visually or physically check that all hooks and attachments were secured to the transfer device prior to the transfer, as indicated in the internal policy. PSW #104 indicated that once they believed the transfer sling was attached to the transfer device, PSW #105 raised resident #004 off of the surface and transferred them without pausing to allow the resident time to adjust or for staff to provide adjustments for the resident, if necessary; to ensure the resident felt safe and secure; or to assess if the resident was off balance in the transfer sling. Resident #004 was transferred on a horizontal angle while PSW #104 supported the resident's legs and feet, and was not turned to face the mast of the lift while still above the surface prior to the transfer, as directed in the internal policy.

During separate interviews, PSWs #109, #114 and #122 indicated it was a common and accepted practice in the home for one staff member to provide personal care, position a transfer sling under the resident, then move on to provide personal care to the next resident without utilizing the transfer sling to complete the transfer, until personal care had been provided to all of the residents on the resident home area. The PSWs further indicated this practice was implemented in an attempt to save time, as it was easier to complete all resident transfers at once, when both staff members and the transfer device were available, instead of one staff member having to wait for another staff

member or the transfer device to become available.

During an interview on a specified date, the Kinesiologist indicated that it was an acceptable practice in the home for staff to place a transfer sling under a resident after care had been provided, leave the resident for a period of time to provide care to other residents, and then return to get the resident up at a later point. The Kinesiologist further indicated the expectation in the home was for staff to check the placement of the sling under the resident prior to beginning the transfer in the transfer device to ensure the transfer sling remained in the proper position. If the transfer sling was found to have shifted, the staff were expected to reposition the sling prior to transferring the resident from the surface. The Kinesiologist indicated it was not an expectation that the staff follow the internal policy related to the transfer device from procedural step one to the final step listed in the policy, as there were no adverse effects on the resident if the sling was left under them, and this practice assisted the front line staff with time management. Lastly, the Kinesiologist indicated that it would only be listed in a resident's plan of care that the sling could remain under them if the sling was present under the resident at all times, not just while waiting to be transferred.

During a follow up interview on a later specified date, Inspector #672 reviewed the internal policy related to the transfer device with the Kinesiologist. The Kinesiologist indicated that they had misunderstood some of the questions during the initial interview, and the expectation in the home was for two staff members to position a transfer sling under the resident, then conduct the transfer. The Kinesiologist further indicated it was not an acceptable practice in the home to leave a transfer sling under a resident, then go on to assist other residents with personal care, and complete all of the resident transfers via the transfer device after care had been provided, as that practice was not safe for residents and went against the directions provided to staff in the internal policy.

During an interview, the Administrator indicated it was an expectation in the home for staff to follow all internal policies and procedures, including the internal safe lift and transfer policy related to the transfer device.

The licensee failed to ensure that PSWs #104 and #105 adhered to the internal policy related to the transfer device and used safe transferring and positioning techniques when assisting resident #004 during a transfer with the transfer

device. As a result, the resident sustained an identified injury which required the resident to be transferred to the hospital and receive an identified intervention.

The severity of the issue was determined to be a level 3 as there was actual harm to resident #004. The scope of the issue was a level 1. The licensee had a level 3 compliance history related to previous non-compliance under the LTCHA, 2007, r. 36.

(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 29, 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:

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 22nd day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office