Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 27, 2024

Inspection Number: 2024-1365-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare West Williams, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12 -14, 18 - 22, 2024.

The following intakes were inspected in this complaint inspection:

- Intakes: #00127696 and #00128053 – Continence Care and Bowel Management, Housekeeping, Laundry and Maintenance, Food, Nutrition and Hydration, Resident Care and Support Services and Responsive Behaviours

The following intakes were inspected in this Critical Incident inspection:

- Intakes: #00124726, #00127187, #00130016 – Infection Prevention and Control
- Intake: #00126295 – Transferring and Positioning Techniques
- Intake: #00126620 and #00130008 – Falls and Prevention and Management
- Intake: #00129336 – Responsive Behaviours
- Intake: #00132054 – Resident Care and Support Services

The following **Inspection Protocols** were used during this inspection:

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from abuse.

Rationale and Summary
A resident sustained injuries during an altercation with another resident.

Residents are at risk of injury when they are not protected from incidents of abuse.

Sources: Critical Incident 2880-000020-24, Progress Notes, Assessments, and interview with staff.

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Reeducate a staff on the home's policies and procedures related to lifts and transfers. There must be a record of this education kept in the home which includes all materials reviewed, the date the education was provided and completed, and signed by the staff as well as the individual providing the education.
2. Conduct, at minimum, an audit of nine transfers per week (two person transfers only), performed by staff on the specified home area. Audits are to be discrete and completed for a period of one month. Audits must include a balance of days, evenings, and night shift and different staff when able.
3. Maintain a record of the audits in the home, including the dates, who conducted the audits, the staff members being audited, and the results and actions taken in response, if any.

Grounds

The licensee failed to ensure staff used safe transferring and positioning devices and techniques when assisting two residents.

The Home's Policy, Resident Lift and Transfer Program stated that "Manual Lifting means moving a resident who cannot weight bear or physically assist without the use of a mechanical lift. This is contrary to this policy".

Home's Policy, Resident Fall Prevention Program stated that "The resident is not to be moved off the floor until the head-to-toe assessment has been completed by a Registered Staff, Physician, NP or paramedic. The decision to move a resident will be based on the assessment of injury (major or minor) and the overall safety of the resident in the environment in which they fell. If it is safe to move the resident from the floor, a mechanical lift must be used unless the resident is able to stand with minimal assistance from staff and the transfer should be overseen by the nurse in case an injury was not determined during the initial assessment".

a) A resident required two-person extensive assistance during transfers.

A staff assisted the resident with a transfer, alone. The resident fell and vocalized pain. In response, the staff and a visitor of the resident began to manually transfer the resident from the floor back to their personal device. Another staff entered the room and assisted with the manual transfer.

Three persons were required to successfully assist the resident back into their personal device, as the resident was not able to stand with minimal assistance. Registered Staff were not notified of the fall until the resident was already transferred into their personal device.

A Registered Nurse said that it is important to assess a resident after a fall to ensure they do not have an injury. There are risks that a transfer could be unsafe as it could worsen the resident's condition.

During the home's investigation, the staff said that they were aware of the resident's transfer status, however, they felt they could do it alone as they observed another staff transfer by themselves prior.

The other staff said that they had historically transferred the resident alone, despite being aware of their transfer status.

The resident said that a variety of staff were transferring them alone often, and on every shift.

Sources: Resident's Clinical Documentation, Home's Internal Investigation, Home's policies and procedures (LTC-ON-200-05-04, LTC-ON-200-05-03), interview with RN, DOC, and other staff.

b) A resident required two-person extensive assistance with all transfers.

The inspector observed a staff respond to a resident's request to transfer to the toilet.

The staff performed four transfers at this time without the assistance of another staff member.

Director of Care said that staff are expected to check a resident's transfer status prior to assisting them to ensure transfers are safe.

When staff fail to ensure safe transferring and positioning devices and techniques are used, residents are at risk of injury.

Sources: Observation, Internal Investigation Notes, Interview with Director of Care, and other staff.

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This order must be complied with by

January 10, 2025

Ministry of Long-Term Care
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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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