Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2016	2016_353589_0003	001342-16	Complaint

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East TORONTO ON M1R 5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST SCARBOROUGH ON M1R 5B1

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

JOANNE ZAHUR (589)

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): January 19, 20, 21, 22 and 27, 2016.

This inspection is related to a critical incident and complaint log # 001342-16, related to the unsafe transferring of a resident.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Nurse Managers (NMs), Director of Environmental Services (DES), Registered staff, Personal Support Workers (PSWs), Arjo Huntleigh Service Technician, Substitute Decision Maker (SDM), resident.

During the course of the inspection, the inspector(s) conducted observations of resident care, staff to resident interactions, reviewed resident health records, the home's investigation notes, critical incident report, and relevant policies and procedures related to this inspection.

During

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

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

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

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

Findings/Faits saillants :

The licensee failed to ensure staff use safe transferring and positioning devices or techniques when assisting resident #001.

Record review of an identified critical incident report (CIR), and the home's internal investigation notes revealed on an identified date in January 2016, resident #001

sustained injuries while being transferred by staff #125. Staff #125 performed the transfer without assistance. The above mentioned CIR revealed that staff #125 confirmed that the identified transfer aid was not in good repair.

Interview with staff #125 revealed that he/she had noted that the identified transfer aid was not in good repair and had been for a while. Staff #125 revealed that the identified transfer aid would engage and appeared to be in good repair so staff were still using it. Staff #125 further revealed that on an identified date in January 2016, while resident #001 was being toileted in bathroom located within the spa room he/she complained that was tired of sitting and needed to get up. Staff #125 asked him/her to wait until another staff could assist. Staff #125 revealed he/she then decided to assist resident #001 up off the toilet just enough to provide care, hoping this would provide some relief to resident #001 while he/she waited for another staff member to assist the resident into a mobility aid.

On an identified date in January 2015, Police Services were contacted to conduct an investigation as a result of multiple injuries diagnosed in hospital that resident #001 had sustained. During the course of their investigation Police Services seized the transfer aid. Police Services closed their investigation as the SDM of resident #001 did not want to pursue criminal charges.

On an identified date in January 2016, observations of the above mentioned transfer aid were conducted at Police Services by the inspector. These observations revealed the transfer aid was not in good working order.

On an identified date in January 2016, an interview with resident #001 revealed that most times there is only one staff present when asked by the inspector, "How many staff were present on an identified date in January 2016, when he/she was being transferred with the mechanical lift?" While answering resident #001 also raised his/her hand with one finger up.

Record review of the home’s internal investigation notes revealed resident #001 during an interview with the staff #100 also stated there is usually only one staff member present when being transferred with a transfer aid.

Record review of the home’s policy titled: Mobility and Minimal Lift Program, # F-20, revised September 15, 2015, page 3 states, “when using the total lift or the sit-to-stand (SSL), it is mandatory that two staff are present”.

Record review of the written plan of care with a completion date of on an identified date in December 2015, revealed under the transferring focus that resident #001 required a " two person constant guidance and physical assist with use of two identified assistive aids.

Record review of the minimum data set-resident assessment instrument (MDS-RAI) annual assessment on an identified date in December 2015, revealed resident #001 required a two person physical assist using a transfer aid.

Interview with staff #125 revealed he/she had received education on safe transferring and positioning techniques and confirmed that on an identified date in January 2016, he/she did not use safe transferring and positioning devices or techniques when assisting resident #001.

Interview with the DOC confirmed that staff #125 did not use safe transferring and positioning devices or techniques when assisting the resident #001.

The scope is of this incident is related to resident #001, however an interview with staff #105 revealed that additional residents on an identified floor were transferred using the identified transfer aid. The severity is actual harm occurred as result of unsafe transferring technique and unsafe use of a broken sling buckle. The Compliance History Report showed a prior voluntary plan of correction was issued on an identified date in March 2015. As a result of scope, severity and the home's previous compliance history a compliance order is warranted. [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 O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

The licensee failed to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

Record review of critical incident report (CIR), and the home's internal investigation notes revealed on an identified date in January 2016, resident #001 sustained injuries while being transferred with a transfer aid. Staff #125 performed the transfer without assistance. The above mentioned CIR revealed that staff #125 confirmed that the transfer aid was not in good repair.

On an identified date in January 2015, Police Services were contacted to conduct an investigation as a result of multiple injuries diagnosed in hospital that resident #001 had sustained. During the course of their investigation Police Services seized the transfer aid.

On an identified date in January 2016, observations by the inspector of the above mentioned transfer aid were conducted at Police Services by the inspector. These observations revealed the transfer aid was not in good repair.

Interviews with staff #110, #125 and #126 revealed that the transfer aid had not been in good repair since December 2015. The above mentioned staffs revealed that the identified transfer aid had been reported to the nurse but could not remember which nurse. The above mentioned identified staff further stated that the transfer aid had not been replaced because the home did not have any in supply. The above mentioned identified staff revealed they had continued to use the transfer aid as it would remain closed once engaged even though they knew it was not proper procedure.

Interview with the staff #105 revealed that additional residents on an identified floor required the use of the identified transfer aids.

Record review of the following homes' policies titled:
-Equipment Care & Equipment, policy #F-60, revised January 26, 2015, revealed that equipment deemed unsafe will be removed from patient care areas and labeled accordingly. Unsafe equipment must be removed from area of use, and reported to maintenance/DOC/nurse manager.
-Personal Support Worker, job description, policy #7.14, reviewed January 12, 2015, revealed PSWs are to report hazardous situations or unsafe equipment to the RN/RPN immediately.
-Emergency Care Equipment/O2 Equipment, policy #F-65, revised January 26, 2015, revealed mechanical lifts will be checked daily and documented using appendix A.

Appendix A revealed daily mandatory checklists for ceiling lift, hoyer lift and mechanical standing lift inspections. The checklist for the mechanical standing lift included the checking of the wheels, brakes, steering handles secure, remote hand control function, battery charged and secure, lock out buttons functional, scale operation (if applicable), all hooks present and secure, lift arm secure and moves freely and sling clean and in good condition.

Record review of the home's scheduled preventative maintenance revealed there is a recurring work order that occurs the last Friday of every month where the home's assistive transfer aids were inspected to ensure all are in good repair by the home's maintenance staff. even though staff interviews revealed

Interview with staff #118 revealed he/she had completed the monthly audit for the home's transfer aids in December 2015. An work order completed on an identified floor an identified date in December 2015, had been signed off by staff #118 ensuring all transfer aids were in good repair even though identified staff #110, #125 and #126 revealed that an identified transfer aid was not in good repair.

Record review of the home's service agreement with an identified equipment service provider included annual inspections of all assistive transfer aids and bathing apparatus. The last annual audit was conducted on three identified dates in October 2015.

Record review of the daily mandatory checklist up to an identified date in January 2016, for an identified floor revealed that all of the items to inspect on transfer aids had been checked off as safe and in good repair. On an identified date in January 2016, staff #126 revealed and confirmed he/she had completed the daily mandatory checklist indicating all items to be checked were in good repair even though an identified transfer aid had not

been in good repair. Staff #125, #126 and #110 also revealed an identified transfer aid had not been in good repair since at least December 2015. The home could not locate the daily checklist for December 2015.

Interview with the DOC confirmed that the home failed to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

The scope is of this incident is related to resident #001, however an interview with staff #105 revealed additional residents on an identified floor required the use of transfer aids. The severity is actual harm occurred as result of the unsafe use of an identified transfer aid that was not in good repair. The Compliance History Report showed a prior written notice was issued on an identified date in April 2014. As a result of scope, severity and the home's previous compliance history a compliance order is warranted. [s. 90. (2) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan of care.

Record review of critical incident report and the home's internal investigation notes revealed on an identified date in January 2016, resident #001 sustained injuries while being transferred with an assistive aid. The identified CIR revealed staff #125 performed the transfer without assistance from another staff member.

On an identified date in January 2016, during an interview with resident #001 when asked what happened he/she revealed that the "young girl had lifted him/her alone" and

that most times there is only one staff when he/she is transferred with a transfer aid. During the interview while answering the above mentioned question resident #001 also raised his/her hand indicating one finger up.

Record review of the home’s internal investigation notes revealed when resident #001 was interviewed by staff #100 he/she also stated there is usually only one staff member present when being transferred with a mechanical lift.

Record review of the home’s policy titled: Mobility and Minimal Lift Program, # F-20, revised September 15, 2015, page 3 states, “when using the total lift or the sit-to-stand (SSL), it is mandatory that two staff are present”.

Record review of the written plan of care with a completion date on an identified date in December 2015, revealed under the transferring focus that resident #001 required a “two person constant guidance and physical assist with use of identified transfer aids".

Record review of the minimum data set-resident assessment instrument (MDS-RAI) annual assessment on an identified date in December 2015, revealed resident #001 required the use of identified transfer aids when being transferred.

Interview with staff #125 revealed on on an identified date in January 2016, resident #001 was complaining that he/she was tired of sitting on the toilet. Staff #125 decided to lift resident #001 slightly off the toilet using a transfer aid unassisted to provide care and provide some relief while waiting for another staff member to complete the transfer into a mobility aid. Staff #125 revealed resident #001's plan of care required a two person assist with the use of identified transfer aids for all transfer. Staff #125 confirmed he/she had not provided care to resident #001 a specified in the plan of care.

Interviews with the DOC and staff #100 confirmed that PSW #125 had not provided care as set out in the plan of care to resident #001 as specified in the plan of care. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #4: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee failed to ensure the written report included actions taken in response to the incident, including the outcome or current status of resident #001.

Record review of critical incident report (CIR) revealed that on an identified date in January 2016, resident #001 was being provided with continence care in the spa room using a transfer aid. The CIR further revealed, "while being transferred from the toilet back to his/her mobility aid, resident #001 let go of the of the hand grab bars resulting in his/her legs bending forward with staffs #125 and #126 catching resident #001 preventing a fall and putting him/her safely into the mobility aid". The CIR further revealed in the analysis and follow-up that the incident was being investigated and the results of this investigation would be updated on the report.

Record review of the identified CIR and the home's internal investigation notes revealed on on an identified date in January 2016, staff #125 admitted to operating the transfer aid unassisted when the incident occurred.

On on an identified date in January 2016, resident #001 was sent to hospital after the long term care home received a mobile x-ray confirmation of injury to an identified body area. Record review of the hospital's assessment also revealed injuries to identified areas of resident #001's body. Resident #001 was re-admitted to the long term care home on an identified date in January 2016 with resident specific care needs for an identified period of time.

Interview with DOC # 102 confirmed that as of January 27, 2016, had not been amended to reflect the results of the incident investigation and the current status of resident #001. [s. 107. (4) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

Issued on this 29th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589)
Inspection No. / No de l'inspection :	2016_353589_0003
Log No. / Registre no:	001342-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 17, 2016
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE 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

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff uses safe transferring techniques when assisting resident #001, and other residents who require transfers with mechanical lifts.

This plan should include methods for monitoring front line staff, to ensure that they comply with the home's transfer and lifts policies, and with residents' individual plans of care.

The plan must be submitted to Joanne.Zahur@ontario.ca on or before February 29, 2016.

Grounds / Motifs :

1. The licensee failed to ensure staff use safe transferring and positioning devices or techniques when assisting resident #001.

Record review of an identified critical incident report (CIR), and the home's internal investigation notes revealed on an identified date in January 2016, resident #001 sustained injuries while being transferred by staff #125. Staff #125 performed the transfer without assistance. The above mentioned CIR revealed that staff #125 confirmed that the identified transfer aid was not in good repair.

Interview with staff #125 revealed that he/she had noted that the identified transfer aid was not in good repair and had been for a while. Staff #125 revealed that the identified transfer aid would engage and appeared to be in good repair so staff were still using it. Staff #125 further revealed that on an identified date in January 2016, while resident #001 was being toileted in bathroom located within the spa room he/she complained that was tired of sitting and needed to get up.

Staff #125 asked him/her to wait until another staff could assist. Staff #125 revealed he/she then decided to assist resident #001 up off the toilet just enough to provide care, hoping this would provide some relief to resident #001 while he/she waited for another staff member to assist the resident into a mobility aid.

On an identified date in January 2015, Police Services were contacted to conduct an investigation as a result of multiple injuries diagnosed in hospital that resident #001 had sustained. During the course of their investigation Police Services seized the transfer aid. Police Services closed their investigation as the SDM of resident #001 did not want to pursue criminal charges.

On an identified date in January 2016, observations of the above mentioned transfer aid were conducted at Police Services by the inspector. These observations revealed the transfer aid was not in good working order.

On an identified date in January 2016, an interview with resident #001 revealed that most times there is only one staff present when asked by the inspector, "How many staff were present on an identified date in January 2016, when he/she was being transferred with the mechanical lift?" While answering resident #001 also raised his/her hand with one finger up.

Record review of the home's internal investigation notes revealed resident #001 during an interview with the staff #100 also stated there is usually only one staff member present when being transferred with a transfer aid.

Record review of the home's policy titled: Mobility and Minimal Lift Program, # F-20, revised September 15, 2015, page 3 states, "when using the total lift or the sit-to-stand (SSL), it is mandatory that two staff are present".

Record review of the written plan of care with a completion date of on an identified date in December 2015, revealed under the transferring focus that resident #001 required a " two person constant guidance and physical assist with use of two identified assistive aids.

Record review of the minimum data set-resident assessment instrument (MDS-RAI) annual assessment on an identified date in December 2015, revealed resident #001 required a two person physical assist using a transfer aid.

Interview with staff #125 revealed he/she had received education on safe transferring and positioning techniques and confirmed that on an identified date in January 2016, he/she did not use safe transferring and positioning devices or techniques when assisting resident #001.

Interview with the DOC confirmed that staff #125 did not use safe transferring and positioning devices or techniques when assisting the resident #001.

The scope is of this incident is related to resident #001, however an interview with staff #105 revealed that additional residents on an identified floor were transferred using the identified transfer aid. The severity is actual harm occurred as result of unsafe transferring technique and unsafe use of a broken sling buckle. The Compliance History Report showed a prior voluntary plan of correction was issued on an identified date in March 2015. As a result of scope, severity and the home's previous compliance history a compliance order is warranted. [s. 36.] (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that describes how the licensee will ensure that the home's procedures are implemented to ensure that mechanical lifts are kept in good repair and maintained at a level that meets manufacturer specifications, at a minimum.

The plan to achieve compliance shall include, but is not limited to the following:
-the development, implementation and monitoring of a process to ensure that all staff who provide direct care to residents requiring the use of slings with mechanical lifts and all maintenance staff who are responsible for completing safety checks on slings and mechanical lifts:
• are aware of the home's policy for equipment safety checks
• are aware of how to effectively audit equipment such as lifts and slings, and
• are aware of the home's policy and process related to equipment that is unsafe and/or not in good working order.

The plan must be submitted to Joanne.Zahur@ontario.ca on or before February 29, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

Record review of critical incident report (CIR), and the home's internal investigation notes revealed on an identified date in January 2016, resident #001 sustained injuries while being transferred with a transfer aid. Staff #125 performed the transfer without assistance. The above mentioned CIR revealed that staff #125 confirmed that the transfer aid was not in good repair.

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Interviews with staff #110, #125 and #126 revealed that the transfer aid had not been in good repair since December 2015. The above mentioned staffs revealed

that the identified transfer aid had been reported to the nurse but could not remember which nurse. The above mentioned identified staff further stated that the transfer aid had not been replaced because the home did not have any in supply. The above mentioned identified staff revealed they had continued to use the transfer aid as it would remain closed once engaged even though they knew it was not proper procedure.

Interview with the staff #105 revealed that additional residents on an identified floor required the use of the identified transfer aids.

Record review of the following homes' policies titled:
-Equipment Care & Equipment, policy #F-60, revised January 26, 2015, revealed that equipment deemed unsafe will be removed from patient care areas and labeled accordingly. Unsafe equipment must be removed from area of use, and reported to maintenance/DOC/nurse manager.
-Personal Support Worker, job description, policy #7.14, reviewed January 12, 2015, revealed PSWs are to report hazardous situations or unsafe equipment to the RN/RPN immediately.
-Emergency Care Equipment/O2 Equipment, policy #F-65, revised January 26, 2015, revealed mechanical lifts will be checked daily and documented using appendix A.

Appendix A revealed daily mandatory checklists for ceiling lift, hoyer lift and mechanical standing lift inspections. The checklist for the mechanical standing lift included the checking of the wheels, brakes, steering handles secure, remote hand control function, battery charged and secure, lock out buttons functional, scale operation (if applicable), all hooks present and secure, lift arm secure and moves freely and sling clean and in good condition.

Record review of the home's scheduled preventative maintenance revealed there is a recurring work order that occurs the last Friday of every month where the home's assistive transfer aids were inspected to ensure all are in good repair by the home's maintenance staff. even though staff interviews revealed

Interview with staff #118 revealed he/she had completed the monthly audit for the home's transfer aids in December 2015. An work order completed on an identified floor an identified date in December 2015, had been signed off by staff #118 ensuring all transfer aids were in good repair even though identified staff #110, #125 and #126 revealed that an identified transfer aid was not in good

repair.

Record review of the home's service agreement with an identified equipment service provider included annual inspections of all assistive transfer aids and bathing apparatus. The last annual audit was conducted on three identified dates in October 2015.

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Interview with the DOC confirmed that the home failed to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

The scope is of this incident is related to resident #001, however an interview with staff #105 revealed additional residents on an identified floor required the use of transfer aids. The severity is actual harm occurred as result of the unsafe use of an identified transfer aid that was not in good repair. The Compliance History Report showed a prior written notice was issued on an identified date in April 2014. As a result of scope, severity and the home's previous compliance history a compliance order is warranted. [s. 90. (2) (b)] (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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