Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2020	2020_763116_0001	000271-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Winbourne Park
1020 Westney Road North AJAX ON L1T 4K6

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

SARAN DANIEL-DODD (116), MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 7, 8, 9, 10, 2020.

the following intake was completed during this inspection:
- Log #000271-20 related to transferring and positioning.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), registered staff members (RNs & RPNs), personal support workers (PSWs), physiotherapist assistant (PTA), and substitute decision maker (SDM) of resident #001.

During the course of the inspection, the inspectors conducted resident and staff interviews, reviewed residents' health records, staffing schedules, investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The Ministry of Long Term Care (MLTC) received a CIS report related to an unsafe transfer involving resident #001.

Resident #003 and #004's written plan of care indicates that they are at risk for falls and require the use of an identified device.

During the inspection, inspector #116 observed the devices to be in place for both residents however, at the time of the observation they did not activate as required.

Inspector #116 brought the concern to the attention of registered staff #109 who made efforts to repair the devices however, they were not in working order.

Interviews held with PSW staff members #107, #108 and registered staff #109 indicated being aware of the purpose of the required devices for resident's #003 and #004 and indicated that all members of staff are responsible for monitoring the equipment to ensure they are in working condition.

Further interview with the DOC indicated that staff are expected to check the functioning of the devices at pre-established times and report any concerns to the registered staff. The DOC further acknowledged that the care set out in the plan of care in relation to the required devices for resident's #003 and #004 was not provided as specified on an identified date. [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(s) as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was transferred using safe transferring and positioning devices.

The Ministry of Long Term Care (MLTC) received a CIS report related to an unsafe transfer involving resident #001 of which the resident was taken to the hospital.

Review of resident #001's progress notes indicated resident #001 was found with an identified injury on a specified date. Resident #001 was taken to the hospital four days later and diagnosed with a confirmed condition.

Review of a required assessment and the written plan of care indicated resident #001 required specified equipment and assistance with transfers.

Interviews held with PSW #100 and RPN #101, indicated resident #001 was to be transferred using the specified equipment and identified assistance.

In separate interviews with Inspector #762, PSW #103 and #104, indicated resident #001 was transferred with equipment which contravened from the written plan of care on an identified date.

In an interview with inspector #762, DOC #102 indicated resident #001 was transferred incorrectly on the identified date, and as a result, staff did not use safe transferring and positioning devices.

The licensee has failed to ensure that resident #001 was transferred using safe transferring and positioning devices. [s. 36.]

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 staff use safe transferring and positioning devices when assisting residents, to be implemented voluntarily.

WN #3: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after an incident that caused an injury, for which resident #001 was taken to the hospital.

The Ministry of Long Term Care (MLTC) received a CIS report related to an incident that caused injury to resident #001 of which the resident was taken to the hospital.

In an interview with inspector #762, DOC #102 indicated that the home had become aware of the incident involving resident #001 seven days prior to the CIS submission to the Director.

The licensee has failed to ensure that the Director is informed no later than one business day after an incident that caused an injury as a result of an improper transfer, for which resident #001 was taken to the hospital. [s. 107. (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 that the Director is informed no later than one business day after any incident that causes an injury to a resident that results 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 31st day of January, 2020

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

Original report signed by the inspector.