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
Oct 9, 2020	2020_751649_0017	003003-20, 003004-20, 006216-20, 008800-20, 010425-20, 012747-20, 016970-20	Critical Incident System

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 Humber Heights
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

JULIEANN HING (649), IANA MOLOGUINA (763)

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): August 12, 13, 14, 17, 18, 19, 20, 24, 25, 26, 27, 28, 31, September 1, 2, 3, 4, and 8, 2020.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Logs #003003-20 and #003004-20 related to plan of care and transfer and positioning techniques.
Logs #006216-20/ CIS #2957-000016-20, #008800-20/ CIS #2957-000018-20, #010425-20/ CIS #2957-000021-20 related to falls prevention and management.
Logs #012747-20/ CIS #2957-000023-20 and #016970-20/ CIS #2957-000028-20 related to prevention of abuse and neglect.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, staff training records, conducted observations related to the home's care processes, staff to resident interactions, and reviewed relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the assistant general manager (AGM), director of nursing care (DNC), assistant director of nursing care (ADNC), registered nurses (RNs), registered dietitian (RD), registered practical nurses (RPNs), neighbourhood coordinators (NCs), program for active living (PAL), kinesiologist/exercise therapist, resident assessment instrument (RAI) coordinators, personal support workers (PSWs), family member, and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **9 WN(s)**
- **4 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #002	2019_641665_0024	763

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #009, #013, #011, #018, and #019 as specified in the plan.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), related to resident #009's fall that resulted in an injury.

During observation by Inspector #649 on August 14, 2020, the inspector asked PSW #100 assigned to resident #009 if the resident was supposed to be wearing a specific device, and they responded no. PSW #100 acknowledged that they had not provided care to the resident that day, and when the inspector further inquired how long the resident had not been wearing the specific device the PSW told the inspector a couple of months.

In a subsequent interview with PSW #100, they explained that they worked as a team with PSW #101, and that they had not been providing care to resident #009; care was being provided by PSW #101. They further told the inspector that at the time of the observation they were not aware that resident #009 required the specific device. They went on to explain that they asked PSW #101 who told them that they always put the specific device on the resident, but when the inspector had inquired with PSW #100 at the time of the above observation the resident was not wearing the specific device. They

told the inspector they were not aware of resident #009 using the specific device as it did not show up as a task in point of care (POC).

In an interview with PSW #101, they explained that it was resident #009's shower day and at the time of the inspector's observation they had forgotten to put the specific device on the resident, and had left it in the shower room. PSW #101 acknowledged that the care set out in resident #009's plan of care was not provided to the resident as specified in the plan, since they were not wearing the specific device during the above observation.

In an interview with RPN #113, they told the inspector that the resident should be wearing the specific device at all times, and acknowledged that resident #009's plan of care was not followed.

In an interview with DNC #140 they were informed of the non-compliance. They told the inspector that staff are expected to be aware of which residents require the specific device. [s. 6. (7)]

2. As a result of non-compliance identified for resident #009 the sample was expanded to resident #013.

During observation by Inspector #649 on August 18, 2020, the inspector observed that the resident was not wearing a specific device; this observation was confirmed with PSW #107.

In an interview with PSW #106 who had provided care to resident #013, acknowledged that the resident was not wearing a specific device at the time of the above observation as it was soiled, and they did not have an extra one available. According to the PSW the nurse said they would get them one.

In an interview with RPN #114, they told the inspector that when PSW #106 came to them and asked for a specific device they immediately told them where they were located, so they could retrieve it themselves. The RPN further explained if they are busy, the PSW should be able to go to an identified room and retrieve the specific device themselves. The RPN denied that the PSW had to wait on them to retrieve the specific device and confirmed that resident #013's plan of care was not followed. [s. 6. (7)]

3. As a result of non-compliance identified for resident #013 the sample was expanded to

resident #018.

A review of resident #018's plan of care indicated they required an identified device when they were up in their mobility device.

During observation by Inspector #649 on August 27, 2020, the inspector observed resident #018 was not using an identified device when they were up in their mobility device, unattended in their room.

In an interview with PSW #127, they told the inspector that during an identified period of time they would remove resident #018's device to change their incontinent brief. The PSW confirmed that the resident was supposed to have the identified device on their mobility device when they were in their room unattended.

In an interview with RPN #125, they told the inspector that the reason for the device was to deter the resident from self transfers, promote safety, and reduce the risk of falls. The RPN acknowledged based on the above mentioned observation the resident's plan of care was not followed. DNC #140 was informed of the non-compliance. [s. 6. (7)]

4. A CIS report was submitted to the MLTC related to resident #011's injury.

A review of resident #011's care plan indicated that they required an identified equipment to help prevent falls from their bed.

During observation by Inspector #649 on August 25, 2020, an identified equipment was not observed on the resident's bed; this observation was confirmed with RPN #117.

RPN #117 told the inspector that resident #011 was cohorted on another home area for a couple of months during the Coronavirus (COVID-19) pandemic. They explained that the identified equipment may not have returned with the resident when they returned to their original home area.

Another observation by Inspector #649 was conducted on August 27, 2020, an identified equipment was not observed on the resident's bed; this observation was confirmed with RPN #118 who immediately requested a replacement.

In an interview with RPN #118, they confirmed that resident #011's plan of care was not followed, since the identified equipment was not observed on the resident's bed.

In an interview with DNC #140, they acknowledged that the resident's plan of care was not followed, and stated that the identified equipment could have been missed when the resident was cohorted on another home area, and moved to a different room on that home area during the pandemic. [s. 6. (7)]

5. (i) A CIS report was submitted to the MLTC alleging that resident #019 had inappropriately touched resident #020.

According to resident #019's progress notes specified monitoring was initiated on August 19, 2020, after the above incident.

During observation by Inspector #649 on September 2, 2020, resident #019 was observed lying in bed, awake, alone with the television on, and no monitoring was present with the resident.

In an interview with PSW #151, they told the inspector that they had stepped away from resident #019 for approximately 10 minutes to attend a new admission huddle, and that the resident was asleep when they left. The inspector inquired if the resident should be left alone and the PSW responded that if the resident is sleeping, they can go to the washroom.

In separate interviews with NC #134, ADNC #136 who was covering as the Behavioural Supports Ontario (BSO) lead, and DNC #140, they all confirmed that resident #019's plan of care was not followed.

(ii) A review of resident #019's written care plan indicated to ensure that the resident was not placed beside residents of the opposite gender.

Further review indicated that resident #019's care plan was not followed since incidents involving residents #020, #021, and #022 occurred when resident #019 was sitting beside residents of the opposite gender.

In an interview with DNC #140, they acknowledged that resident #019's plan of care was not followed. [s. 6. (7)]

6. The licensee has failed to ensure that the staff and others who provided direct care to resident #009 were kept aware of the contents of the resident's plan of care and have

convenient and immediate access to it.

A CIS report was submitted to the MLTC,related to resident #009's fall that resulted in an injury

During observation by Inspector #649 on August 14, 2020, the inspector asked PSW #100 assigned to resident #009 if the resident was supposed to be wearing a specific device, and they responded no. PSW #100 acknowledged that they had not provided care to the resident that day, and when the inspector further inquired how long the resident had not been wearing the specific device, the PSW told the inspector a couple of months.

In a subsequent interview with PSW #100, they explained that they worked as a team with PSW #101, and that they had not been providing care to resident #009; care was being provided by PSW #101. They further told the inspector that at the time of the observation they were not aware that resident #009 required a specific device. The PSW was not aware that the resident was at risk for falls. They went on to explain that they asked PSW #101 who told them that they always put a specific device on the resident, but when the inspector had inquired with PSW #100 at the time of the above observation the resident was not wearing the specific device. They told the inspector they were not aware of resident #009 using a specific device as it did not show up as a task in POC.

In an interview with RPN #113, they explained that the PSW is expected to be aware of the contents of resident #009's plan of care, especially if the resident is at risk for falls and required fall interventions. They confirmed that a task for resident #009's specific device was not set up in POC for the PSW to document, and told the inspector they will create a task for this intervention.

In an interview with DNC #140, they explained that their expectation is that the RPN and PSW discuss those residents that require specific devices, so they are aware. They further stated that the home will be looking into adding this task in POC so that all staff are aware. [s. 6. (8)]

7. The licensee has failed to ensure that resident #012 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

As a result of non-compliance identified for resident #009 the sample was expanded to

resident #012.

A review of resident #012's written care plan indicated under falls that the resident required the use of a specific device.

During observation by Inspector #649 on August 18, 2020, resident #012 was observed in the lounge and was not wearing the specific device; this observation was confirmed with PSW #105.

In an interview with PSW #108 who had provided care to resident #012 on the day of the above observation, told the inspector that the resident had refused to wear the specific device. The inspector further inquired how long the resident had been refusing to wear the specific device, and was told approximately two to three weeks sporadically. The PSW acknowledged that the resident's care plan should have been updated to indicate the residents' refusal of the specific device. The PSW told the inspector that every time the resident refused they would let the nurse know, and when they toilet the resident they would attempt to put the specific device on the resident. Subsequently PSW #108 told the inspector that the nurse was only aware that resident #012 had been refusing the specific device for the past two days.

RPN #104 told the inspector they were aware that resident #012 had been refusing the specific device, and acknowledged that the resident's care plan should have been updated. The inspector further inquired how long they have been aware of the resident's refusal of the specific device, and they told the inspector approximately one month.

In a subsequent interview with RPN #104, they explained that the PSW should document in POC the resident's refusal of the specific device. However, upon further record review this task was not initiated in POC for the PSW to document. According to the nurse, they did not always document when the PSW told them about the residents' refusal of the specific device in point click care (PCC). The RPN further told the inspector that sometimes the resident would wear the specific device and when staff would check on the resident, they would find that they had removed a part of the specific device and would only be wearing one portion.

A review of resident #012's progress notes in PCC for an identified period, did not indicate any documentation of the resident's refusal of the specific device.

In an interview with PSW #143, they told the inspector that it had been more than six

months that resident #012 had been refusing to wear the specific device at bedtime, and when they put the device on the resident, they would remove it. According to PSW #143, RPN #120 was aware of this.

In an interview with RPN #120, they could not recall how long resident #012 had been refusing the specific device. Initially they told the inspector one month, then they said before the pandemic, and then maybe last year.

In an interview with DNC #140, they acknowledged that resident #012's care plan should have been reviewed and revised. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and that residents, are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #020, #021, and #022 were protected from sexual abuse.

Under O. Reg. 79/10, s.5 for the purpose of the definition of “sexual abuse” in subsection 2 of the Act, “sexual abuse” means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

(i) A CIS report was submitted to the MLTC, alleging that resident #019 touched resident #020 inappropriately while they were sitting together.

Neither resident would be able to provide informed consent.

A review of resident #019’s progress notes indicated that the above incident was witnessed by PSW #133.

In an interview with PSW #133, they told the inspector that they had observed resident #019 touched resident #020 inappropriately while they were sitting together. They immediately told resident #019 to stop and reported this to RPN #120. PSW #133 confirmed their observation was sexual abuse and told the inspector that this was not the first incident.

Further review of resident #019’s progress notes indicated two previous incidents of resident #019 inappropriately touching residents #021 and #022. These two incidents were never reported to the Director.

(ii) According to resident #019’s progress notes they had inappropriately touched resident #021.

Resident #021 would not be able to provide informed consent.

In an interview with PSW #138, who had witnessed the above incident between residents #019 and #021 told the inspector that prior to this incident, they had observed the two residents sitting side by side, and resident #019 was holding and rubbing resident #021’s hands. The PSW explained that they brought the neighbourhood coordinator (NC) #134 over to where the two residents were sitting to observe them. PSW #138 alleged that they were told by NC #134 that it was just a friendly gesture and they let it go. Approximately one hour later resident #019 was observed inappropriately touching resident #021. The PSW felt that the incident could have been avoided and confirmed that sexual abuse had occurred between residents #019 and #021. PSW #138 reported their observation to NC #134 and RPN #120.

In an interview with NC #134, they denied being aware of the above incident involving residents #019 and #021.

In an interview with RPN #120, they acknowledged being aware of the above incident between residents #019 and #021, as reported by PSW #138. RPN #120 acknowledged in the presence of DNC #140 that they did not report the incident to the charge nurse; alleged they forgot, did not complete an incident report according to the home's process, did not complete an assessment of resident #021; asked the PSW who was providing care to resident #021 to let them know if they saw anything, and did not inform resident #021's power of attorney (POA) of the incident. The RPN was unsure if the incident between resident #019 and resident #021 constituted sexual abuse, and told the inspector that the resident's POA can provide consent for them to touch each other.

(iii) According to resident #019's progress notes, resident #024's family member reported to RPN #135 that they had observed resident #019 touching resident #022 a few hours earlier. The progress note indicated that the family member was advised by RPN #135 to inform the nurse immediately if such situations reoccurs. RPN #135 informed resident #019's POA of the incident who was visiting the home at the time. The documentation also stated that the charge nurse was notified.

In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019 touching resident #022. They were unable to confirm or deny if resident #019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched resident #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together when the incident occurred.

In an interview with DNC #140, they acknowledged that sexual abuse had occurred with residents #020, #021, and #022. [s. 19. (1)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents #021 and #022 was complied with.

A review of the home's policy titled Code of Conduct under the home's Investigation Process for suspected resident to resident abuse, policy #04-06A reviewed on December 1, 2018, directed staff as follows:
-The registered team member will ensure the immediate needs of both residents have been met, including but not limited to:
a. Immediate response for safety of all persons
b. Immediate care to the resident(s) that is individualized, respectful, culturally and ethically sensitive, in a therapeutic environment
c. Medical assistance, if required
d. Assistance with personal care
e. Emotional support
f. Arrangements for ongoing emotional and physical support and care
-Registered team member will notify the charge nurse for additional support to complete the abuse algorithm to identify action required.
-Charge nurse to notify the appropriate member of the leadership team, director of care, or leadership team member on-call.
-Charge nurse or designate to notify the resident's substitute decision-maker, if any, and any other person specified by the resident.

A CIS report was submitted to the MLTC, alleging that resident #019 had inappropriately touched resident #020, while they were sitting together.

(i) Record review of resident #019's progress notes indicated that a staff member reported to RPN #120 that resident #019 had inappropriately touched resident #021. There was no documentation of this incident in resident #021's clinical record in PCC, or any documentation of action taken by the nurse, with regards to an assessment of resident #021, including notifying the charge nurse and the resident's Substitute Decision-Maker (SDM).

In an interview with RPN #120, they acknowledged in the presence of DNC #140 being aware of the above incident between residents #019 and #021, as reported by PSW #138. They confirmed that they did not report this incident to the charge nurse, did not complete an assessment of resident #021, and did not inform resident #021's SDM of the incident. The lack of action by RPN #120 led to the home's policy not being followed.

(ii) According to resident #019's progress notes, resident #024's family member reported to RPN #135 a few hours later that they had observed resident #019 inappropriately touched resident #022.

In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019 touching resident #022. They were unable to confirm or deny if resident #019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024. This incident of resident to resident sexual abuse was not identified by RPN #135 as such. As a result, they did not report the incident to the charge nurse as sexual abuse, did not complete an assessment of resident #022, and did not inform resident #022's SDM of the incident. RPN #135's failure to clarify with resident #024's family member what they had observed, resulted in the home's policy not being followed.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched resident #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together.

In an interview with DNC #140, they were informed of the above concerns and agreed

that several areas of the home's policy were not complied with for residents #021 and #022, when they were inappropriately touched by resident #019. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

(a) A review of the home's policy titled Care, under Restraint and PASD Procedure in LTC, policy #04-52 reviewed on August 6, 2019, indicated that staff did not comply with the home's restraint and personal assistance service device (PASD) policy specifically related to the following areas:
(i) Alternatives to Restraint/ PASD Assessment in PCC: Must be completed for every resident before a restraint is considered. The rationale for the use of the restraint will be documented, as well as what alternatives were tried with comments on their effectiveness. Alternatives should be trialled for at least three shifts to determine whether they are effective, unless a risk is identified. The assessment must be completed prior to application of the restraint and every quarter thereafter.
(ii) Consent: Consent must be obtained from the resident/SDM prior to the application of a restraint. The discussion regarding use of a physical restraint will be documented in the progress notes.
(iii) Restraint Approval: A physician, physician assistant (PA), or nurse practitioner (NP) must approve the use of a physical restraint before it can be applied. No PRN order are

permitted. The order must specify the instructions related to the use of the device:
-Type of device to be used
-Conditions/ Instructions for application (when the device is to be applied and the reason it is being used)
(iv) Restraint Monitoring: PSWs will perform restraint monitoring in Point of Care. The following will be completed and documented in POC:
-The resident will be monitored when the restraint is in place at least every hour by a PSW or designate to ensure that the restraint is intact, and the resident is comfortable (safety check).
-The resident will be released from the restraint and repositioned at least once every two hours or more frequently as required.
(v) Re-Assessment: The registered team member will reassess the resident's condition and evaluate the effectiveness of the restraint at least every eight hours. Reassessment will be recorded in Point of Care.
(vi) Training: All team members will be trained on Restraints/ PASD policy as part of general orientation.

Record review, observations and staff interview indicated the following related to the use of the first and second devices for resident #013:

During observation by Inspector #649 on August 18, 2020, of resident #013 in regards to a specific device the inspector observed that the resident had a first device on their mobility device. A subsequent observation was conducted on August 19, 2020, when the inspector observed that the resident was wearing the second and first devices while up in the mobility device; this observation was confirmed with PSW #152.

A review of resident #013's clinical record indicated that they were unable to provide consent for the use of the devices. According to resident #013's progress they were admitted to the home with the two devices. According to PSWs documentation in POC they started to document on the application of the two devices two weeks after the resident's admission. Documentation indicated that the application of the second device was discontinued less than two months later, whereas staff continued to document on the application of the first device for a couple more months.

According to the resident's clinical record the Alternatives to Restraint/ PASD assessment was completed two weeks after the resident's admission, even though they had been using both devices since admission. Further review of the assessment indicated that no other alternatives with a less restraining device was tried. There was no

documentation that the devices were tried for three shifts prior to their application, and was not reviewed quarterly thereafter as per the home's policy.

In an interview with RPN #114, they confirmed that the Alternatives to Restraint/ PASD assessment was completed.

A review of the home’s consent form did not indicate if the resident’s substitute decision-maker (SDM) consented to any of the devices; since neither was checked on the form. Further review of this form indicated that the resident will use the first device when they were up in their mobility device to prevent sliding and prevent falls. The home’s documentation identified the use of the first device as one type of device when in fact, it was another type of device, since the resident was unable to remove it independently. This was confirmed by the occupational therapist's (OT) documentation. There was no signed consent from the resident’s SDM for the use of the second device, thus indicating that the home's policy was not followed.

In an interview with RPN #114, they confirmed that there was no signed consent from the resident’s SDM for the use of the second device. After a review of the resident’s clinical record with the inspector, they confirmed that the first device being documented as one type of device was indeed another type.

According to the home’s policy and legislation a physician or registered nurse in the extended class (EC) are required to approve the use of the two devices. The inspector was unable to locate any evidence that this process was followed when resident #013 started to use the devices.

A review of resident #013’s physician orders indicated that the physician ordered the first device to be in place until an assessment was completed, and to send a referral for an assessment. A couple of months later, the physician ordered to apply the first device as per family request for comfort and to assist with an activity of daily living. These two orders from the physician were unclear as to the purpose of the device, and did not follow the home's policy which includes an assessment before the application of any devices.

In an interview with RPN #114, they confirmed that there was a physician order for resident #013’s use of the first device, but no physician order for the use of the second device.

According to the home's policy, PSWs are required to document in POC hourly monitoring of the second device and should release and reposition the resident at a minimum of every two hours. Record review demonstrated that the home's policy was not complied with since the home mistakenly classified the device, and did not complete the hourly monitoring associated with that device.

PSWs started to document in POC two weeks after the resident's admission, on the two devices after the Alternatives to Restraint/ PASD assessment was completed, even though progress notes indicated that the resident was admitted with the two devices. The OT assessed the resident and determined that the first device was a restrain. According to POC documentation the application of resident's second device had been discontinued for a couple of months even though the inspector observed the resident using the device on August 19, 2020. The application of the two devices were documented in POC at a frequency of every two hours instead of hourly as required for one of the devices. The home's documentation indicated that the two devices were considered one type of device when it was really another device, therefore the home's policy for documentation of hourly monitoring was not followed for the devices.

In an interview with RPN #114, they confirmed that there was no hourly monitoring of the second device by the PSWs. They confirmed after a review of the resident's clinical record with the inspector that there was little documentation of hourly monitoring for the first device.

According to the home's policy, registered staff will reassess the resident's condition and evaluate the effectiveness of a restraint at least every eight hours in Point of Care. A review of registered staff documentation related to the use of the first device indicated that this task was initially set up in POC for a few days then discontinued. It was then initiated in the electronic-medication administration record (e-MAR) for approximately two months. There was no registered staff monitoring every eight hours for the use of the resident's first device for two months, when PSWs were documenting it's application in POC. There was no registered staff monitoring every eight hours for the second device for the same time when PSWs were documenting it's application in POC, therefore the home's policy was not complied with.

In an interview with RPN #114, they confirmed after a review of the resident's clinical record with the inspector that there was little documentation of hourly monitoring of the two devices.

A review of the home's training records provided by assistant general manager (AGM) #150 of staff (RNs, RPNs, and PSWs) who completed the 2019 training on the devices indicated only 78 percent (%) of staff completed the training.

In an interview with DNC #140, they confirmed after a review of the resident's clinical record with the inspector the above mentioned areas of non-compliance.

(b) A review of the home's policy #04-52 titled Restraint & PASD Procedures in LTC with a last reviewed date of August 6, 2019, indicated that staff did not comply with the home's restraint and PASD policy specifically related to the following area:
-The resident or SDM has consented to the use of the PASD and the consent form has been reviewed, signed, and dated annually. A discussion with the resident or SDM must take place informing them of the risks associated with using the device as well as the alternatives tried without success.

As a result of non-compliance identified for resident #013 the sample was expanded to resident #018.

A review of resident #018's care plan indicated that they required the use of a specified device when up in their mobility device to deter them from self transfers, and to reduce the risk of falls.

Record review indicated that a consent form for the use of the device was last signed by resident #018's SDM 20 months ago.

In an interview with RPN #125, they confirmed that the last written consent from the resident's SDM for the use of the device was last signed 20 months ago and acknowledged that the consent should be reviewed annually.

In an interview with DNC #140, they acknowledged that the home's policy was not complied with since the consent for the first device was last signed 20 months ago, and should be reviewed annually with the resident's SDM. They told the inspector they had a conversation with the resident's SDM who agreed that the resident no longer required the first device, and had it removed after the inspector inquired about it with RPN # 125. [s. 29. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. As part of the condition of licence, the licensee failed to comply with order #002 issued February 10, 2020, under inspection #2019_641665_0024 with a compliance due date of July 30, 2020, which required the licensee to do the following:

(a) Ensure all registered staff and personal support workers (PSWs) receive training/re-training on safe use of all mechanical lifts used in the home including a specified mechanical lift, and safe transferring and positioning of residents.

(b) Develop and implement an auditing tool to ensure that staff are assisting residents with transferring using safe transferring devices and techniques including use of a specified mechanical lift, according to the home's written policies. Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

The grounds of the order indicated that the licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents #004, #001 and #006. Resident #004 sustained a fall with injury, as a result of improper use of a specified mechanical lift by PSW #122 and #123. The inspection report indicated that 100% of registered staff and PSWs did not receive training on the use of the specified mechanical

lift, or training on transfer techniques and lift use for 2018. Further, the inspection report indicated several incidents of unsafe transfer and lift techniques used by staff for residents #004, #001, and #006.

(A) The home's most recent training records for lift and transfer training were reviewed. AGM #150 indicated that the home was in the process of completing lift and transfer training, including training on a specified mechanical lift, but had put a hold on training during the home's management of the COVID-19 outbreak. Training by the equipment company representative was provided in the fall of 2019 to the two PSWs involved in the original fall incident for resident #004 as well as the PAL Kinesiologist/ Exercise Therapist for the home at the time. The company representative also provided training for staff in the fall of 2019. Further training was held by the PAL kinesiologist/ exercise therapist from January to March 2020. AGM #150 provided a record of lift and transfer sign-in sheets for the above training dates, which indicated that only 67% of all registered staff and PSWs participated in this training.

The education material that was used to facilitate training sessions was reviewed; there was no specific education material mentioned on the use of a specified mechanical lift or any other brand of lifts. AGM #150 confirmed that the education package for lift and transfer training did not include specific information on the specified mechanical lift. They indicated that the previous PAL kinesiologist/ exercise therapist was expected to review the specifics of the specified mechanical lift use with the home staff as they provided the training on lifts and transfers, since they were directly trained on their use by the company representatives.

PSW #138 confirmed they participated in the lift and transfer training in the winter of 2020, and indicated that there were no specifics on the specified mechanical lift reviewed, or any other specific lift during that training. PSW #138 explained that they completed the lift and transfer training on another floor of the home and whatever lift was available on the unit was used as part of the training; there was no discussion about specifics on different functionalities of lift brands.

RPN #120 also confirmed they participated in the lift and transfer training in winter 2020, and did not recall a review of specifics on the specified mechanical lift or any other lift conducted. RPN #120 was not able to tell the inspector the difference between the specified mechanical lift or any other lift brands used in the home.

(B) Kinesiologist (KIN) #149 was interviewed and confirmed they were in charge of

implementing the auditing tool that was developed for ensuring staff assist residents with transferring using safe transferring devices and techniques including the use of the specified mechanical lift. KIN #149 provided a copy of the only audit completed as part of complying with this section of the above order. The audit was completed in August 2020 on a different mechanical lift. KIN #149 indicated that further audits have been scheduled going forward on a weekly basis.

MLTC internal records were reviewed and indicated that the compliance due date for the order was July 30, 2020, and that the MLTC did not request a compliance plan as part of this order. AGM #150 was interviewed and indicated that the home was in the process of complying with the indicated order and was under the impression that the July 30, 2020 due date was the due date for the home to submit a compliance plan and not the compliance due date. AGM #150 indicated that at the time the order was issued, they were a new employee in the home and not aware of the order process. AGM #150 consulted with their corporate office and submitted a compliance plan on July 29, 2020, indicating that the implementation date for the lift and transfer training was scheduled for the third week of August 2020; and the use of a developed audit for safe lift use and transfer techniques was to be completed monthly starting September 1, 2020. AGM #150 indicated they were planning to ask for an extension to the order due date after submitting the compliance plan, but inspectors then entered the home for inspection on August 12, 2020. AGM #150 confirmed that the home failed to complete the training and auditing that was required to comply with order #002 under inspection #2019_641665_0024 by the compliance due date. [s. 101. (3)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated.

A CIS report was submitted to the MLTC alleging that resident #019 had inappropriately touched resident #020 while they were sitting together.

Further review of resident #019's progress notes indicated there were two previous incidents of resident #019 inappropriately touching residents #021 and #022.

(i) Record review of resident #019's progress notes indicated, a staff reported to RPN #120 that resident #019 had inappropriately touched resident #021.

In an interview with RPN #120, they acknowledged in the presence of the DNC #140 that they did not report the incident of resident #019 inappropriately touching resident #021 to the charge nurse. As a result of RPN #120 failure to report the incident, resulted in no action taken by the home in terms of an immediate investigation.

(ii) According to resident #019's progress notes, resident #024's family member reported to RPN #135 three hours later that they had observed resident #019 touched resident #022. The progress note indicated that the family member was advised by RPN #135 to inform the nurse immediately if such situations reoccurs. RPN #135 informed resident

#019's SDM of the incident who was visiting the home at the time. The documentation also stated that the charge nurse was notified.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched resident #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together when the incident occurred.

In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019 touching resident #022. They were unable to confirm or deny if resident #019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024. This incident of resident to resident sexual abuse was not identified as such by RPN #135, therefore no follow-up action was taken, and as a result the incident was not immediately investigated.

In an interview with DNC #140, they told the inspector the home did not have any investigation notes and did not submit any CIS report with regards to the above two mentioned incidents, and acknowledged that the home had failed to immediately investigate. [s. 23. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A CIS report was submitted to the MLTC alleging that resident #019 had inappropriately touched resident #020, while they were sitting together.

Further review of resident #019's progress notes indicated there were two previous incidents of resident #019 inappropriately touching residents #021 and #022. These two incidents were never reported to the Director.

(i) A review of resident #019's progress notes, indicated a staff reported to RPN #120 that the resident had inappropriately touched resident #021.

In an interview with RPN #120, they acknowledged in the presence of the DNC #140 that they did not report the incident of resident #019 inappropriately touching resident #021 to the charge nurse.

(ii) According to resident #019's progress notes, resident #024's family member reported

to RPN #135 three hours later that they had observed resident #019 touched resident #022.

In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019 touching resident #022. They were unable to confirm or deny if resident #019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together.

In an interview with DNC #140, they acknowledged the home did not report the above two incidents of resident to resident sexual abuse to the Director. According to the DNC they only became aware of the incident between residents #019 and #21 when they reported the incident between residents #19 and #20. The DNC was not employed by the home at the time the incident occurred. [s. 24. (1)]

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 a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessment and interventions, and that resident's #019 responses to interventions were documented.

A CIS report was submitted to the MLTC, alleging that resident #019 inappropriately touched resident #020 while they were sitting together.

Further review of resident #019's progress notes indicated there were two previous incidents where resident #019 had inappropriately touched residents #021 and #022.

(i) A review of resident #019's progress notes, indicated staff reported to RPN #120 that the resident had inappropriately touched resident #021. In the presence of DNC #140, RPN #120 acknowledged in an interview that that they did not report the incident to the charge nurse, did not complete an assessment of resident #021, and did not complete an incident report according to the home's process. The inspector asked the RPN what action they took when they became aware of the incident, they responded that the PSW had already separated the residents, and they documented that resident #019 likes to touch other residents.

(ii) According to resident #019's progress notes, indicated resident #024's family member reported to RPN #135, three hours later that they had observed resident #019 touched resident #022. In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019

touching resident #022. They were unable to confirm or deny if resident #019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched resident #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together when the incident occurred.

A referral was faxed to the Geriatric Mental Health Outreach Team (GMHOT) indicating that resident #019 had inappropriate sexual behavior. Further review of the concerns listed on the referral indicated that resident #019 sometimes inappropriately touched staff. There was no mention of resident #019 inappropriately touching residents of the opposite gender despite documentation of this behaviour in a recent progress note.

The inspector was unable to find any evidence of documentation of an assessment, reassessment and interventions implemented in response to resident #019 inappropriately touching residents #021 and #022 in the above mentioned incidents.

In an interview with ADNC #136 who was covering as the BSO lead and started their employment in January 2020, told the inspector that they only became aware of resident #019’s responsive behaviour after the incident. According to ADNC #136 they never received report of any previous incidents involving resident #019 and told the inspector that the resident was not on the home’s BSO program.

In an interview with DNC #140, they confirmed that there was no documentation of an assessment, reassessment and interventions implemented for resident #019, and no referral was completed to personal expression response team (PERT) according to the home’s process after the above mentioned incidents. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessment and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: 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. (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 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 resident #017 with the routine activity of living.

As a result of non-compliance identified for resident #013, the sample was expanded to resident #017.

Record review indicated that resident #017 was admitted with the use of a specified device. Further review of the resident's clinical record indicated that an identified assessment was not completed prior to the resident's use of the device.

The inspector was unable to locate any documentation that the specified assessment was completed for resident #017.

The inspector observed resident #017 on August 25, 2020, while they were up in their mobility device, and they demonstrated the removal and application of the specified device, thereby confirming that the device was not a restraint but a PASD.

In separate interviews with RPN #122 and DNC #140, they both acknowledged that the assessment was not completed for resident #017 for use of the specified device. [s. 33. (4) 1.]

Issued on this 10th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JULIEANN HING (649), IANA MOLOGUINA (763)
Inspection No. / No de l’inspection :	2020_751649_0017
Log No. / No de registre :	003003-20, 003004-20, 006216-20, 008800-20, 010425-20, 012747-20, 016970-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 9, 2020
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 Humber Heights 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Pauline Dell'Oso

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 Long-Term Care

Ministère 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 # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_641665_0024, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the residents #009, #013, #011, #018, and #019's plan of care is provided to residents as specified in the plan.

The plan must include, but is not limited, to the following:
1. Develop and implement a process to ensure that PSWs follow the resident's plan of care related to the use of specified devices. Also follow resident #019's care plan to ensure they are not seated beside residents of the opposite gender.
2. Implement a process to ensure that staff providing one to one monitoring of a resident do not leave the resident unattended.

Please submit the written plan for achieving compliance to Julie Ann Hing, LTC Homes Inspector, MOHLTC, by email to: TorontoSAO.generalemail@ontario.ca by October 26, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #009, #013, #011, #018, and #019 as specified in the plan.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), related to resident #009's fall that resulted in an injury.

During observation by Inspector #649 on August 14, 2020, the inspector asked PSW #100 assigned to resident #009 if the resident was supposed to be wearing a specific device, and they responded no. PSW #100 acknowledged that they had not provided care to the resident that day, and when the inspector further inquired how long the resident had not been wearing the specific device the PSW told the inspector a couple of months.

In a subsequent interview with PSW #100, they explained that they worked as a team with PSW #101, and that they had not been providing care to resident #009; care was being provided by PSW #101. They further told the inspector that at the time of the observation they were not aware that resident #009 required the specific device. They went on to explain that they asked PSW #101 who told them that they always put the specific device on the resident, but when the inspector had inquired with PSW #100 at the time of the above observation the resident was not wearing the specific device. They told the inspector they were not aware of resident #009 using the specific device as it did not show up as a task in point of care (POC).

In an interview with PSW #101, they explained that it was resident #009's shower day and at the time of the inspector's observation they had forgotten to put the specific device on the resident, and had left it in the shower room. PSW #101 acknowledged that the care set out in resident #009's plan of care was not provided to the resident as specified in the plan, since they were not wearing the specific device during the above observation.

In an interview with RPN #113, they told the inspector that the resident should be wearing the specific device at all times, and acknowledged that resident #009's plan of care was not followed.

In an interview with DNC #140 they were informed of the non-compliance. They told the inspector that staff are expected to be aware of which residents require the specific device. (649)

2. As a result of non-compliance identified for resident #009 the sample was expanded to resident #013.

During observation by Inspector #649 on August 18, 2020, the inspector observed that the resident was not wearing a specific device; this observation was confirmed with PSW #107.

In an interview with PSW #106 who had provided care to resident #013, acknowledged that the resident was not wearing a specific device at the time of the above observation as it was soiled, and they did not have an extra one available. According to the PSW the nurse said they would get them one.

In an interview with RPN #114, they told the inspector that when PSW #106 came to them and asked for a specific device they immediately told them where they were located, so they could retrieve it themselves. The RPN further explained if they are busy, the PSW should be able to go to an identified room and retrieve the specific device themselves. The RPN denied that the PSW had to wait on them to retrieve the specific device and confirmed that resident #013's plan of care was not followed. (649)

3. A CIS report was submitted to the MLTC related to resident #011's injury.

A review of resident #011's care plan indicated that they required an identified equipment to help prevent falls from their bed.

During observation by Inspector #649 on August 25, 2020, an identified equipment was not observed on the resident's bed; this observation was confirmed with RPN #117.

RPN #117 told the inspector that resident #011 was cohorted on another home area for a couple of months during the Coronavirus (COVID-19) pandemic. They explained that the identified equipment may not have returned with the resident when they returned to their original home area.

Another observation by Inspector #649 was conducted on August 27, 2020, an identified equipment was not observed on the resident's bed; this observation was confirmed with RPN #118 who immediately requested a replacement.

In an interview with RPN #118, they confirmed that resident #011's plan of care was not followed, since the identified equipment was not observed on the

resident's bed.

In an interview with DNC #140, they acknowledged that the resident's plan of care was not followed, and stated that the identified equipment could have been missed when the resident was cohorted on another home area, and moved to a different room on that home area during the pandemic. (649)

4. As a result of non-compliance identified for resident #013 the sample was expanded to resident #018.

A review of resident #018's plan of care indicated they required an identified device when they were up in their mobility device.

During observation by Inspector #649 on August 27, 2020, the inspector observed resident #018 was not using an identified device when they were up in their mobility device, unattended in their room.

In an interview with PSW #127, they told the inspector that during an identified period of time they would remove resident #018's device to change their incontinent brief. The PSW confirmed that the resident was supposed to have the identified device on their mobility device when they were in their room unattended.

In an interview with RPN #125, they told the inspector that the reason for the device was to deter the resident from self transfers, promote safety, and reduce the risk of falls. The RPN acknowledged based on the above mentioned observation the resident's plan of care was not followed. DNC #140 was informed of the non-compliance. (649)

5. (i) A CIS report was submitted to the MLTC alleging that resident #019 had inappropriately touched resident #020.

According to resident #019's progress notes specified monitoring was initiated on August 19, 2020, after the above incident.

During observation by Inspector #649 on September 2, 2020, resident #019 was observed lying in bed, awake, alone with the television on, and no monitoring

was present with the resident.

In an interview with PSW #151, they told the inspector that they had stepped away from resident #019 for approximately 10 minutes to attend a new admission huddle, and that the resident was asleep when they left. The inspector inquired if the resident should be left alone and the PSW responded that if the resident is sleeping, they can go to the washroom.

In separate interviews with NC #134, ADNC #136 who was covering as the Behavioural Supports Ontario (BSO) lead, and DNC #140, they all confirmed that resident #019's plan of care was not followed.

(ii) A review of resident #019's written care plan indicated to ensure that the resident was not placed beside residents of the opposite gender.

Further review indicated that resident #019's care plan was not followed since incidents involving residents #020, #021, and #022 occurred when resident #019 was sitting beside residents of the opposite gender.

In an interview with DNC #140, they acknowledged that resident #019's plan of care was not followed.

The severity of this non-compliance was identified as actual harm, the scope was identified as patterned. Review of the home's compliance history revealed a compliance order (CO) was issued on February 10, 2020, under inspection report #2019_641665_0024 for non-compliance with the LTCHA, 2007, s. 6. (7) that has not yet been complied with. Due to the severity of actual harm and previous non-compliance, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA 2007.

Specifically, the licensee must:

1. Retrain RPNs #120, #135 and neighbourhood coordinator #134 on identification of sexual abuse.

2. Ensure that all residents including residents #020, #021 and 022 are protected from sexual abuse.

The home must maintain a documentation record of the education and training material content provided above, including the dates of when the education was provided, who provided the education, and signed staff attendance records.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #020, #021, and #022 were protected from sexual abuse.

Under O. Reg. 79/10, s.5 for the purpose of the definition of "sexual abuse" in subsection 2 of the Act, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

(i) A CIS report was submitted to the MLTC, alleging that resident #019 touched resident #020 inappropriately while they were sitting together.

Neither resident would be able to provide informed consent.

A review of resident #019's progress notes indicated that the above incident was witnessed by PSW #133.

In an interview with PSW #133, they told the inspector that they had observed resident #019 touched resident #020 inappropriately while they were sitting together. They immediately told resident #019 to stop and reported this to RPN #120. PSW #133 confirmed their observation was sexual abuse and told the inspector that this was not the first incident.

Further review of resident #019's progress notes indicated two previous incidents of resident #019 inappropriately touching residents #021 and #022. These two incidents were never reported to the Director.

(ii) According to resident #019's progress notes they had inappropriately touched resident #021.

Resident #021 would not be able to provide informed consent.

In an interview with PSW #138, who had witnessed the above incident between residents #019 and #021 told the inspector that prior to this incident, they had observed the two residents sitting side by side, and resident #019 was holding and rubbing resident #021's hands. The PSW explained that they brought the neighbourhood coordinator (NC) #134 over to where the two residents were sitting to observe them. PSW #138 alleged that they were told by NC #134 that it was just a friendly gesture and they let it go. Approximately one hour later resident #019 was observed inappropriately touching resident #021. The PSW felt that the incident could have been avoided and confirmed that sexual abuse had occurred between residents #019 and #021. PSW #138 reported their observation to NC #134 and RPN #120.

In an interview with NC #134, they denied being aware of the above incident involving residents #019 and #021.

In an interview with RPN #120, they acknowledged being aware of the above incident between residents #019 and #021, as reported by PSW #138. RPN #120 acknowledged in the presence of DNC #140 that they did not report the

incident to the charge nurse; alleged they forgot, did not complete an incident report according to the home's process, did not complete an assessment of resident #021; asked the PSW who was providing care to resident #021 to let them know if they saw anything, and did not inform resident #021's power of attorney (POA) of the incident. The RPN was unsure if the incident between resident #019 and resident #021 constituted sexual abuse, and told the inspector that the resident's POA can provide consent for them to touch each other.

(iii) According to resident #019's progress notes, resident #024's family member reported to RPN #135 that they had observed resident #019 touching resident #022 a few hours earlier. The progress note indicated that the family member was advised by RPN #135 to inform the nurse immediately if such situations reoccurs. RPN #135 informed resident #019's POA of the incident who was visiting the home at the time. The documentation also stated that the charge nurse was notified.

In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019 touching resident #022. They were unable to confirm or deny if resident #019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched resident #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together when the incident occurred.

In an interview with DNC #140, they acknowledged that sexual abuse had occurred with residents #020, #021, and #022.

The severity of this non-compliance was identified as actual harm, the scope was identified as widespread. Review of the home's compliance history revealed a compliance order (CO) was issued on May 13, 2019, under inspection report #2019_641665_0008 for non-compliance with the LTCHA, 2007, s. 19. (1). Due

to the severity of actual harm and previous non-compliance, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2020

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the LTCHA 2007.

Specifically, the licensee must:

1. Retrain RPNs #120 and #135 on the home's policy titled Code of Conduct under the home's Investigation Process for suspected resident to resident abuse (policy #04-06A reviewed on December 1, 2018), related to their roles and responsibilities.

The home must maintain a documentation record of the education and training material content provided above, including the dates of when the education was provided, who provided the education, and signed staff attendance records.

Grounds / Motifs :

1. The licensee had failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents #021 and #022 was complied with.

A review of the home's policy titled Code of Conduct under the home's Investigation Process for suspected resident to resident abuse, policy #04-06A reviewed on December 1, 2018, directed staff as follows:
-The registered team member will ensure the immediate needs of both residents have been met, including but not limited to:
a. Immediate response for safety of all persons
b. Immediate care to the resident(s) that is individualized, respectful, culturally

and
ethically sensitive, in a therapeutic environment
c. Medical assistance, if required
d. Assistance with personal care
e. Emotional support
f. Arrangements for ongoing emotional and physical support and care
-Registered team member will notify the charge nurse for additional support to complete the abuse algorithm to identify action required.
-Charge nurse to notify the appropriate member of the leadership team, director of care, or leadership team member on-call.
-Charge nurse or designate to notify the resident's substitute decision-maker, if any, and any other person specified by the resident.

A CIS report was submitted to the MLTC, alleging that resident #019 had inappropriately touched resident #020, while they were sitting together.

(i) Record review of resident #019's progress notes indicated that a staff member reported to RPN #120 that resident #019 had inappropriately touched resident #021. There was no documentation of this incident in resident #021's clinical record in PCC, or any documentation of action taken by the nurse, with regards to an assessment of resident #021, including notifying the charge nurse and the resident's Substitute Decision-Maker (SDM).

In an interview with RPN #120, they acknowledged in the presence of DNC #140 being aware of the above incident between residents #019 and #021, as reported by PSW #138. They confirmed that they did not report this incident to the charge nurse, did not complete an assessment of resident #021, and did not inform resident #021's SDM of the incident. The lack of action by RPN #120 led to the home's policy not being followed.

(ii) According to resident #019's progress notes, resident #024's family member reported to RPN #135 a few hours later that they had observed resident #019 inappropriately touched resident #022.

In an interview with RPN #135, they advised that they did not clarify with resident #024's family member about the details of their observation of resident #019 touching resident #022. They were unable to confirm or deny if resident

#019 had inappropriately touched resident #022. They told the inspector that resident #024's family member was walking by and had observed resident #019 touching resident #022, and this was not the first time as resident #019 had done the same with resident #024. This incident of resident to resident sexual abuse was not identified by RPN #135 as such. As a result, they did not report the incident to the charge nurse as sexual abuse, did not complete an assessment of resident #022, and did not inform resident #022's SDM of the incident. RPN #135's failure to clarify with resident #024's family member what they had observed, resulted in the home's policy not being followed.

In an interview with resident #024's family member, they told the inspector that they had observed resident #019 inappropriately touched resident #022, and they told resident #019 to stop. According to the family member residents #019 and #022 were sitting together.

In an interview with DNC #140, they were informed of the above concerns and agreed that several areas of the home's policy were not complied with for residents #021 and #022, when they were inappropriately touched by resident #019.

The severity of this non-compliance was identified as actual harm, the scope was identified as patterned. Review of the home's compliance history revealed a Voluntary Plan of Correction (VPC) was issued on May 13, 2019, under inspection report #2019_641665_0008 for non-compliance with the LTCHA, 2007, s. 20. (1). Due to the severity of actual harm and previous non-compliance, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2020

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,

(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and

(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

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

The licensee must be compliant with s. 29. (1) (b) of the LTCHA.

Specifically, the licensee must:

1. Retrain all registered staff (RNs and RPNs) on:
(i) the home's policy titled Care under Restraint and PASD Procedure in LTC, (policy #04-52 reviewed on August 6, 2019).
(ii) policy #04-52 titled Restraint & PASD Procedures in LTC with a last reviewed date of August 6, 2019.
(iii) alternatives to Restraint/ PASD Assessment form.

The training must include:
-how to differentiate a personal assistance service device (PASD) from a restraint.
-documentation and monitoring required for use of a PASD and a restraint.
-when to obtain approval from the physician/registered nurse in extended class, for use of a PASD and a restraint, including specification to be included in the orders.
-obtaining resident's substitute decision-maker (SDM) consent for use of a restraint.
-clear directions to PSWs for PASD and restraint tasks created in point of care (POC).

The home must maintain a documentation record of the education and training material content provided for everything above, including the dates of when the education was provided, who provided the education, and signed staff attendance records.

2. Reassess resident #013's specified devices use.

3. Ensure Alternatives to Restraint/PASD Assessment form is completed in its entirety.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

(a) A review of the home's policy titled Care, under Restraint and PASD Procedure in LTC, policy #04-52 reviewed on August 6, 2019, indicated that staff did not comply with the home's restraint and personal assistance service device (PASD) policy specifically related to the following areas:
(i) Alternatives to Restraint/ PASD Assessment in PCC: Must be completed for every resident before a restraint is considered. The rationale for the use of the restraint will be documented, as well as what alternatives were tried with comments on their effectiveness. Alternatives should be trialled for at least three shifts to determine whether they are effective, unless a risk is identified. The assessment must be completed prior to application of the restraint and every quarter thereafter.
(ii) Consent: Consent must be obtained from the resident/SDM prior to the application of a restraint. The discussion regarding use of a physical restraint will be documented in the progress notes.
(iii) Restraint Approval: A physician, physician assistant (PA), or nurse practitioner (NP) must approve the use of a physical restraint before it can be applied. No PRN order are permitted. The order must specify the instructions related to the use of the device:
-Type of device to be used
-Conditions/ Instructions for application (when the device is to be applied and the reason it is being used)
(iv) Restraint Monitoring: PSWs will perform restraint monitoring in Point of Care. The following will be completed and documented in POC:
-The resident will be monitored when the restraint is in place at least every hour by a PSW or designate to ensure that the restraint is intact, and the resident is comfortable (safety check).
-The resident will be released from the restraint and repositioned at least once every two hours or more frequently as required.
(v) Re-Assessment: The registered team member will reassess the resident's condition and evaluate the effectiveness of the restraint at least every eight hours. Reassessment will be recorded in Point of Care.
(vi) Training: All team members will be trained on Restraints/ PASD policy as part of general orientation.

Record review, observations and staff interview indicated the following related to the use of the first and second devices for resident #013:

During observation by Inspector #649 on August 18, 2020, of resident #013 in regards to a specific device the inspector observed that the resident had a first device on their mobility device. A subsequent observation was conducted on August 19, 2020, when the inspector observed that the resident was wearing the second and first devices while up in the mobility device; this observation was confirmed with PSW #152.

A review of resident #013's clinical record indicated that they were unable to provide consent for the use of the devices. According to resident #013's progress they were admitted to the home with the two devices. According to PSWs documentation in POC they started to document on the application of the two devices two weeks after the resident's admission. Documentation indicated that the application of the second device was discontinued less than two months later, whereas staff continued to document on the application of the first device for a couple more months.

According to the resident's clinical record the Alternatives to Restraint/ PASD assessment was completed two weeks after the resident's admission, even though they had been using both devices since admission. Further review of the assessment indicated that no other alternatives with a less restraining device was tried. There was no documentation that the devices were tried for three shifts prior to their application, and was not reviewed quarterly thereafter as per the home's policy.

In an interview with RPN #114, they confirmed that the Alternatives to Restraint/ PASD assessment was completed.

A review of the home's consent form did not indicate if the resident's Substitute Decision-Maker (SDM) consented to any of the devices; since neither was checked on the form. Further review of this form indicated that the resident will use the first device when they were up in their mobility device to prevent sliding and prevent falls. The home's documentation identified the use of the first device as one type of device when in fact, it was another type of device, since the resident was unable to remove it independently. This was confirmed by the occupational therapist's (OT) documentation. There was no signed consent from the resident's SDM for the use of the second device, thus indicating that the home's policy was not followed.

In an interview with RPN #114, they confirmed that there was no signed consent from the resident's SDM for the use of the second device. After a review of the resident's clinical record with the inspector, they confirmed that the first device being documented as one type of device was indeed another type.

According to the home's policy and legislation a physician or registered nurse in the extended class (EC) are required to approve the use of the two devices. The inspector was unable to locate any evidence that this process was followed when resident #013 started to use the devices.

A review of resident #013's physician orders indicated that the physician ordered the first device to be in place until an assessment was completed, and to send a referral for an assessment. A couple of months later, the physician ordered to apply the first device as per family request for comfort and to assist with an activity of daily living. These two orders from the physician were unclear as to the purpose of the device, and did not follow the home's policy which includes an assessment before the application of any devices.

In an interview with RPN #114, they confirmed that there was a physician order for resident #013's use of the first device, but no physician order for the use of the second device.

According to the home's policy, PSWs are required to document in POC hourly monitoring of the second device and should release and reposition the resident at a minimum of every two hours. Record review demonstrated that the home's policy was not complied with since the home mistakenly classified the device, and did not complete the hourly monitoring associated with that device.

PSWs started to document in POC two weeks after the resident's admission, on the two devices after the Alternatives to Restraint/ PASD assessment was completed, even though progress notes indicated that the resident was admitted with the two devices. The OT assessed the resident and determined that the first device was a restrain. According to POC documentation the application of resident's second device had been discontinued for a couple of months even though the inspector observed the resident using the device on August 19, 2020. The application of the two devices were documented in POC at a

frequency of every two hours instead of hourly as required for one of the devices. The home's documentation indicated that the two devices were considered one type of device when it was really another device, therefore the home's policy for documentation of hourly monitoring was not followed for the devices.

In an interview with RPN #114, they confirmed that there was no hourly monitoring of the second device by the PSWs. They confirmed after a review of the resident's clinical record with the inspector that there was little documentation of hourly monitoring for the first device.

According to the home's policy, registered staff will reassess the resident's condition and evaluate the effectiveness of a restraint at least every eight hours in Point of Care. A review of registered staff documentation related to the use of the first device indicated that this task was initially set up in POC for a few days then discontinued. It was then initiated in the electronic-medication administration record (e-MAR) for approximately two months. There was no registered staff monitoring every eight hours for the use of the resident's first device for two months, when PSWs were documenting it's application in POC. There was no registered staff monitoring every eight hours for the second device for the same time when PSWs were documenting it's application in POC, therefore the home's policy was not complied with.

In an interview with RPN #114, they confirmed after a review of the resident's clinical record with the inspector that there was little documentation of hourly monitoring of the two devices.

A review of the home's training records provided by assistant general manager (AGM) #150 of staff (RNs, RPNs, and PSWs) who completed the 2019 training on the devices indicated only 78 percent (%) of staff completed the training.

In an interview with DNC #140, they confirmed after a review of the resident's clinical record with the inspector the above mentioned areas of non-compliance.

(b) A review of the home's policy #04-52 titled Restraint & PASD Procedures in LTC with a last reviewed date of August 6, 2019, indicated that staff did not comply with the home's restraint and PASD policy specifically related to the

following area:
-The resident or SDM has consented to the use of the PASD and the consent form has been reviewed, signed, and dated annually. A discussion with the resident or SDM must take place informing them of the risks associated with using the device as well as the alternatives tried without success.

As a result of non-compliance identified for resident #013 the sample was expanded to resident #018.

A review of resident #018's care plan indicated that they required the use of a specified device when up in their mobility device to deter them from self transfers, and to reduce the risk of falls.

Record review indicated that a consent form for the use of the device was last signed by resident #018's SDM 20 months ago.

In an interview with RPN #125, they confirmed that the last written consent from the resident's SDM for the use of the device was last signed 20 months ago and acknowledged that the consent should be reviewed annually.

In an interview with DNC #140, they acknowledged that the home's policy was not complied with since the consent for the first device was last signed 20 months ago, and should be reviewed annually with the resident's SDM. They told the inspector they had a conversation with the resident's SDM who agreed that the resident no longer required the first device, and had it removed after the inspector inquired about it with RPN #125.

The severity of this non-compliance was identified as minimal risk, the scope was identified as patterned. Review of the home's compliance history revealed unrelated non-compliance. Due to the severity of risk, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Order / Ordre :

The licensee must be compliant with LTCHA, s. 101 (3).

Specifically, the licensee shall:
(a) Ensure all registered staff and personal support workers (PSWs) receive training/re-training on the safe use of all mechanical lifts used in the home including the specified mechanical lift, and safe transferring and positioning of residents.
(b) Develop and implement an auditing tool to ensure that staff are assisting residents with transferring using safe transferring devices and techniques including use of the specified mechanical lift, according to the home's written policies.

Maintain a written record of the training as well as the audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. As part of the condition of licence, the licensee failed to comply with order #002 issued February 10, 2020, under inspection #2019_641665_0024 with a compliance due date of July 30, 2020, which required the licensee to do the following:

(a) Ensure all registered staff and personal support workers (PSWs) receive

training/retraining on safe use of all mechanical lifts used in the home including a specified mechanical lift, and safe transferring and positioning of residents.

(b) Develop and implement an auditing tool to ensure that staff are assisting residents with transferring using safe transferring devices and techniques including use of a specified mechanical lift, according to the home's written policies. Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

The grounds of the order indicated that the licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents #004, #001 and #006. Resident #004 sustained a fall with injury, as a result of improper use of a specified mechanical lift by PSW #122 and #123. The inspection report indicated that 100% of registered staff and PSWs did not receive training on the use of the specified mechanical lift, or training on transfer techniques and lift use for 2018. Further, the inspection report indicated several incidents of unsafe transfer and lift techniques used by staff for residents #004, #001, and #006.

(A) The home's most recent training records for lift and transfer training were reviewed. AGM #150 indicated that the home was in the process of completing lift and transfer training, including training on a specified mechanical lift, but had put a hold on training during the home's management of the COVID-19 outbreak. Training by the equipment company representative was provided in the fall of 2019 to the two PSWs involved in the original fall incident for resident #004 as well as the PAL Kinesiologist/ Exercise Therapist for the home at the time. The company representative also provided training for staff in the fall of 2019. Further training was held by the PAL kinesiologist/ exercise therapist from January to March 2020. AGM #150 provided a record of lift and transfer sign-in sheets for the above training dates, which indicated that only 67% of all registered staff and PSWs participated in this training.

The education material that was used to facilitate training sessions was reviewed; there was no specific education material mentioned on the use of a specified mechanical lift or any other brand of lifts. AGM #150 confirmed that the

education package for lift and transfer training did not include specific information on the specified mechanical lift. They indicated that the previous PAL kinesiologist/ exercise therapist was expected to review the specifics of the specified mechanical lift use with the home staff as they provided the training on lifts and transfers, since they were directly trained on their use by the company representatives.

PSW #138 confirmed they participated in the lift and transfer training in the winter of 2020, and indicated that there were no specifics on the specified mechanical lift reviewed, or any other specific lift during that training. PSW #138 explained that they completed the lift and transfer training on another floor of the home and whatever lift was available on the unit was used as part of the training; there was no discussion about specifics on different functionalities of lift brands.

RPN #120 also confirmed they participated in the lift and transfer training in winter 2020, and did not recall a review of specifics on the specified mechanical lift or any other lift conducted. RPN #120 was not able to tell the inspector the difference between the specified mechanical lift or any other lift brands used in the home.

(B) Kinesiologist (KIN) #149 was interviewed and confirmed they were in charge of implementing the auditing tool that was developed for ensuring staff assist residents with transferring using safe transferring devices and techniques including the use of the specified mechanical lift. KIN #149 provided a copy of the only audit completed as part of complying with this section of the above order. The audit was completed in August 2020 on a different mechanical lift. KIN #149 indicated that further audits have been scheduled going forward on a weekly basis.

MLTC internal records were reviewed and indicated that the compliance due date for the order was July 30, 2020, and that the MLTC did not request a compliance plan as part of this order. AGM #150 was interviewed and indicated that the home was in the process of complying with the indicated order and was under the impression that the July 30, 2020 due date was the due date for the home to submit a compliance plan and not the compliance due date. AGM #150 indicated that at the time the order was issued, they were a new employee in the

home and not aware of the order process. AGM #150 consulted with their corporate office and submitted a compliance plan on July 29, 2020, indicating that the implementation date for the lift and transfer training was scheduled for the third week of August 2020; and the use of a developed audit for safe lift use and transfer techniques was to be completed monthly starting September 1, 2020. AGM #150 indicated they were planning to ask for an extension to the order due date after submitting the compliance plan, but inspectors then entered the home for inspection on August 12, 2020. AGM #150 confirmed that the home failed to complete the training and auditing that was required to comply with order #002 under inspection #2019_641665_0024 by the compliance due date.

The severity of this non-compliance was identified as minimal risk, the scope was identified as isolated. Review of the home's compliance history revealed unrelated non-compliance. Due to the severity of risk a CO is warranted. (763)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

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 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:

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

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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 9th day of October, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : JulieAnn Hing

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