Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 14, 2016 | 2015_280541_0041 | 033664-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

AMBER MOASE (541), DARLENE MURPHY (103), HEATH HEFFERNAN (622), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY BROWN (602)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): Onsite December 14,-18, 21-23 and 29-31, 2015 and offsite January 7, 2016**

**Nine critical incidents and three complaint logs were inspected concurrently with this RQI.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Directors of Care (DOC), the Environmental Manager, Registered Nurses(RNs), Registered Practical Nurses (RPNs), the Restorative Care Coordinator, the Physiotherapy Assistant, an Activation staff, Personal Care Providers (PCPs), a Family Council representative, the Resident Council President, and Residents. In addition, inspectors also reviewed resident health care records, observed meal service, conducted tours of the home, observed staff to resident interactions and reviewed relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

- **10 WN(s)**
- **4 VPC(s)**
- **3 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2015_396103_0012 | 541 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure all staff participate in the implementation of the infection prevention and control program.

On December 14, 2015, Inspector #103 conducted a full walking tour of the home that included shower and tub rooms. The following observations were made during the tour:

-MacDonald tub room at 0840 hour-two small unlabeled pairs of nail clippers were noted in a white basket in top drawer-one pair was noted to be soiled,
-MacDonald shower room at 0845 hour-one pair of unlabeled, soiled nail clippers was observed on the counter beside the sink,
-Smugglers Cove tub room at 0850 hour-one unlabeled black brush with hair and one used, unlabeled deodorant was observed on the counter; one unlabeled black comb with dander evident was found in the drawer,
-Breakwater shower room at 0915 hour-one pair of soiled unlabeled nail clippers with nail clippings present was observed and two pairs of soiled nail nippers were in a basket on counter,
-Portsmouth shower room at 0935 hour- unlabeled, soiled large nail clippers were observed on the shower wall with nail clippings evident, a large pile of used towels were piled on the floor to the left of the doorway and several used towels and used, disposable gloves were observed on the floor; the shower stall was noted to have three wet, used washcloths on the floor,
-At 1240 hour, the inspector returned to this shower room and observed 10+ soiled, wet facecloths on the floor of the shower stall; one cloth was orange and appeared to be soiled with feces; the unlabeled large nail clipper was still present on shower wall with nail clippings evident,
-Portsmouth tub room at 0940 hour-one large pair of unlabeled nail clippers was found in the top right drawer and were noted to be dirty; second pair of unlabeled, large nail clippers were found in a blue basket next to the sink and were noted to be soiled with clippings,
-At 1245 hour the inspector returned to this area and observed one large and two small unlabeled nail clippers in the blue basket by the sink-all appeared soiled and the large pair had evidence of nail clippings,
-City Park shower at 0950 hour was observed to have one unlabeled, soiled pair of small nail clippers stored with emery boards that appeared to be new/ unused,
-City Park tub room at 1000 hour-one unlabeled black brush with hair evident was observed in top drawer and three black unlabeled combs with dander in them observed in left top drawer.

On December 16, 2015 the following observations were made:
-Portsmouth shower room-dirty nail clippers were found on ledge of shower-nails still evident in the clippers; clippers were also noted to have some rusting evident; these nail

clippers were observed in same location during initial tour of the home two days ago, Portsmouth tub room-dirty large and small nail clippers were found in top right drawer and in a blue basket by the sink; a white, unlabeled hair brush with hair evident was also found in this drawer,
-MacDonald spa room-visibly soiled, large nail clippers on counter by sink and a second pair on white storage unit, visibly soiled with nails,
-MacDonald tub room-1 small used/soiled nail clippers were observed,
-City shower room-visibly dirty pair of small nail clippers found in basket sitting beside an unlabeled used hairbrush with hair visible.

The Administrator was asked to observe the Portsmouth shower and tub room following the inspector's observations. The Administrator confirmed the presence of the soiled and unlabeled nail clippers and the apparent sharing of brushes/combs. The inspector stated similar findings had been observed in eight of the twelve shower/tub room areas.

Personal Care Providers (PCPs) were interviewed from various resident areas and indicated each resident should have labeled nail care equipment that is to be used specifically for their individualized nail care needs and that personal items such as combs and brushes should be labeled and not shared.

The home's Infection Control lead RN #S105 was interviewed and indicated all residents are to have dedicated, labeled nail care equipment that is to be stored at the bedside. She further indicated the nail care equipment should be promptly cleaned and disinfected after use and returned to the bedside and should not be left in the shower/tub room areas. RN #S105 was unable to explain why the large and small soiled nail clippers would be found in the shower/tub rooms and was unlabeled.

RN #S105 indicated the nail nippers that were observed in the Breakwater shower room would be considered shared resident nail equipment as not all residents would require this type of equipment for foot care but would be required for some. RN #S105 indicated shared resident care equipment such as nail nippers would be cleaned and disinfected using Virex II 256 in accordance with the instructions on the bottle.

The inspector was provided with policy, "Nail Clipping Devices", INF-II-89. Under procedure, it indicated:
-remove visible soil
-follow manufacturers guidelines for the disinfectant cleaner (Virex II 256).

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in all Health Care Setting, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices which include nail/foot care instruments indicates the need for meticulous cleaning of nail clippers followed by a high level disinfectant. Virex II 256, which is currently being used by this home, is a hospital grade disinfectant, not a high level disinfectant and therefore is not an effective disinfectant for shared nail care equipment. [s. 229. (4)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that safe transferring techniques were used when assisting residents.

The following finding is related to log 018657-15:

A critical incident report was submitted by the home indicating that on a specified date, PCP #S123 attempted to independently transfer Resident #046 from the wheelchair to the commode. During the transfer, PCP #S123 stepped away from the resident to move the wheelchair when the resident fell backward into the door frame resulting in an injury.

Resident #046's care plan at the time of the fall indicated that the resident requires extensive assistance from two staff for toileting and transfers.

Interviews with RPN #S124 and DOC #S107 confirmed that PCP #S123 knew that Resident #046 was a two-person transfer and had received training related to safe transfers prior to the incident.

PCP #S123 was disciplined as per the home's human resources procedures. [s. 36.]

2. Staff did not use safe transferring techniques when assisting Resident #050 to the toilet as per the residents prescribed two person transfer status.

The following is related to log #021244-15.

On a specified date and time, Resident #050 was found by a PCP staff sitting on the floor beside the toilet in the bathroom. The resident was unable to remember if he/she was assisted to the bathroom or if he/she attempted to go independently. The home's investigation that day revealed that the night shift PCP #S126 completed a one person transfer to toilet resident #050 near the end of the night shift and left the resident sitting on the toilet with the call bell in reach. PCP #S126 advised that this was reported to the day staff prior to her departure that morning.

The care set out in resident #050's plan of care indicates that the resident was a two person transfer at the time of the incident and that the resident required supervision while on the toilet.

Notes from the subsequent meeting with the DOC and PCP #S126 indicate that the PCP advised that she neglected to look at the transfer logo. PCP #S126 was disciplined as per the home's human resources procedures. [s. 36.]

3. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents

The following is related to log #020052-15:
A Critical Incident (CI) report was submitted by the home for improper/incompetent treatment of a resident that results in harm or risk to a resident on a specified date. According to the CI report, the home received a letter written by RN #S128 indicating that PCP #S130 had transferred resident #049 by himself on a specified date when the resident was to have a two-person transfer.

The plan of care for resident #049 in effect on July 28, 2015 indicates the resident requires a mechanical lift with 2 staff for transferring.

RPN #S129 was interviewed and confirmed that PCP #S130 also completed an

independent transfer of resident #051 with a mechanical lift on another specified date. RPN #S129 states she provided a supervisory feedback form on the date of the first unsafe transfer to PCP #S130 for transferring by himself using a mechanical lift. Inspector #541 reviewed the supervisory feedback form and noted it was signed by PCP #S130 the day prior to completing the second unsafe transfer.

It was noted by Inspector #541 that neither resident #049 or #051 were injured as a result of the improper transfers.

The care plan for resident #051 in place at the time of the unsafe transfer indicates the resident uses a ceiling lift with 2 staff for transferring.

According to the home's investigation in to the incident, PCP #S130 indicated being aware resident #051 and #049 require two staff for transfers however PCP #130 did the transfers on his own as he did not want to wait for assistance by another staff member.

PCP #S130 was disciplined as per the home's human resources procedures for completing two-person and mechanical transfers independently.

PCP #S130 failed to use safe transferring techniques when he transferred residents #049 and #051 by himself using a mechanical lift when both residents required two staff members to safely transfer. [s. 36.]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During the stage one observations, the following observations were made by the inspectors:

-Resident #005 Deep gouges down to metal strapping/drywall is rough and protruding at corner by closet, long areas of black marks/scrapes along wall as you enter the room, scrapes in surface on lower edge of closet doors, (541)
-Resident #006 Deep/rough gouges at corner by bathroom and numerous gouges in wall beside closet, (541)
-Resident #010 Deep gouges on the wall corner by the bathroom and closet, surface on lower edge of closet doors are scraped, vent in the bathroom has obvious dust/dirt evident, (541)
-Resident #011 Deep gouges on wall by bathroom door and by bed; one of the closet doors has an open break in the surface along the entire width/surface is not intact, (541)
-Resident #012 Deep gouge and rough surface at corner wall, numerous areas of disrepair to surface at closet wall corner, bottom of bathroom door trim is loose, jagged and protruding, vent in the bathroom has obvious dust/dirt evident, (541)
-Resident #013 Wall in resident's room outside bathroom is scraped with black marks, some pieces of drywall missing, (541)
-Resident #015 Edge of bathroom door is loose, broken and jagged, (103)
-Resident #017 Edge of door frame on bathroom door is broken and loose; corner of bathroom door has missing baseboard-rough area, (103)
-Resident #018 Large areas of unpainted repair on wall by bed and bathroom; appears re-damaged in some areas-especially at corners- deep gouges, baseboard and trim at

bathroom are missing; lower edge of closet is scraped/paint missing; areas also present on wall at end of bed; bathroom also has large areas of disrepair; some repaired and re-damaged, (103)
-Resident #019 Scarring on bottom of closet and bathroom doors; bathroom door frame is loose and very sharp; resident states he/she has hurt his/her ankle on it before; patched hole in ceiling/rough/unfinished; ceiling vent in bathroom is very dirty with obvious dust/dirt, (103)
-Resident #020 Large areas of disrepair where new spackle has been applied but not yet painted at the corner by closet- areas have been re-damaged since repaired; closet is scraped at base and trim at bottom left is pulled away/sticking out; large areas of gouges in bathroom as well; new spackle applied/not yet painted and re-damaged; bathroom door trim is loose at bottom edge of door and jagged, (103)
-Resident #021's room was observed to have a deep gouge in the corner by closet which are rough and jagged to touch; scrapes are noted across lower end of closet doors; there are numerous gouges in the wall at the end of bed and numerous scrapes on the wall in bathroom, (103)
-Resident #023 Small area where corner is gouged at closet; scarring of finish at base of closet and bathroom door, (103)
-Resident #026 Wall beside head of bed has numerous deep gouges in it; surface paint missing and it is rough to touch, (103)
-Resident #027 Deep gouge in wall beside closet, (103)
-Resident #030 Numerous deep gouges at closet wall by resident's bed, (197)
-Resident #031 Wall to the left as you enter room has deep gouges down to metal strapping at corner; orange sized hole in the wall observed beside the closet door, several indentations along wall next to toilet, (197)
-Resident #038 Scuffs on wall as you enter room; paint is scraped and areas where finish is missing/gouged; several gouges noted by closet; area of drywall repaired but unpainted next to toilet paper holder, (197)
-Resident #011 Deep gouges on wall by bathroom door and by bed; one of the closet doors has an open break in the surface along the entire width/surface is not intact, (197)
-City Park shower room-observed to have several areas of disrepair on walls; areas noted where metal stripping is exposed in some areas and missing wall tiles at corners, (103)
-MacDonald Park shower room-disrepair noted -deep gouges in wall at chair height, (103)
-Breakwater tub room- deep gouges in wall near garbage/linen carts (103)

The home's new Environmental Supervisor(ESM)#S106 was interviewed in regards to

the home's process for addressing disrepair. He stated the home fully paints and repairs all resident rooms when the residents are discharged. ESM #S106 indicated that painting and repairs to drywall for occupied rooms are not addressed on a regular basis and only if an extreme case. He also stated the home has a computerized means of requesting all repairs including painting and repairs. According to ESM #106, any staff member can request repairs to be completed when it is identified. [s. 15. (2) (c)]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During the stage one observations, the inspectors noted the majority of residents utilized two quarter bed rails at all times. Residents #011, #020 and #026 health care records were reviewed and observations were made. The quarter bed rails for these three residents were observed to be used daily and none of the care plans indicated the need for bed rails.

The Administrator provided this inspector with the policy, "Bed Rails", RCSM-E-05 which indicated all residents are assessed for the need of raised quarter bed rails and the assessment is to be documented in the resident electronic chart. The policy further indicated the care plan would reflect the need for bed rails.

The inspector was directed to speak with RN Manager #105 in regards to bed rails. The inspector requested the documented assessment of the resident bed system including any steps to prevent bed entrapment. RN Manager #105 was unaware of any assessments completed related to the use of bed rails and stated the home does not complete these assessments.

DOC #107 and the Administrator were both interviewed and indicated they were unaware these assessments were required for residents that utilize quarter bed rails. They further indicated there has been no bed system evaluation completed to include prevention of resident entrapment or other safety issues related to the use of bed rails including height and latch reliability. DOC #107 confirmed the majority of the residents in the home utilize two quarter rails. [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.***

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**WN #5: 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 following finding is related to log #018657-15:

The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

On a specified date, PCP #123 attempted to independently transfer Resident #046 from the wheelchair to the commode. At the time of the incident, Resident #046 was identified to require extensive assistance from two staff for toileting and transferring. During the transfer, PCP #123 stepped away from the resident and the resident fell resulting in a head injury.

The home submitted a Critical Incident Report on three days after the fall under the category of improper/incompetent treatment of a resident that results in harm or risk of harm to a resident. The report indicated that DOC #107 was not notified of the incident until the next day at midday and at this point a report was made to the Director.

The home's Abuse policy # ADM-VI-06 Ab dated March 2015 was reviewed. The policy indicates that an individual receiving report of alleged abuse or neglect is to "notify the DOC or designate or if after hours, the senior manager on call immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse or neglect and initiate the investigation".

It is noted the incident occurred on the evening shift. During an interview, DOC #107 indicated that RN #S127 should have either called the after-hours pager herself or notified her immediately after the incident occurred. [s. 20. (1)]

2. The following is related to log #002411-15:

On a specified date the home submitted a Critical Incident under improper/incompetent treatment of resident #046 which occurred 25 days earlier.

Inspector #622 interviewed PCP #S138 who stated, staff received training regarding abuse and neglect at least yearly, and according to the homes procedure for PCP staff on reporting of suspected or witnessed incidents of abuse or neglect, they are to report to the RN or managers or the DOC. PCP #138 stated she felt the incident she observed on the specified date was neglect and she reported the concern to the RN on shift. PCP #138 stated she placed a type written document pertaining to the incident under the Director of Care #131's door who was away on vacation and later submitted the letter to the Director of Care #107 25 days after the incident occurred.

Inspector #622 interviewed the Director of Care (DOC) # 107 who stated staff receive training regarding abuse and neglect annually. She also stated she did not know the incident occurred until she found the type written document from PCP staff # 138 under her door on 25 days after the incident occurred. It was at this time when the report was submitted to the Ministry of Health and Long Term Care.

Inspector #622 interviewed the Director of Care (DOC) # 131 who confirmed the Personal Care Providers (PCPs) are to report to the Registered Practical Nurse (RPN) immediately, the RPN reports to Registered Nurse (RN) manager and if we (management) are here, we start the process immediately with notification of the Ministry of Health and Long Term Care either via CIS or by phone. If management is not here, the RN would make a phone call to the off hours Ministry hotline and also call the manager on call.

Inspector #622 reviewed the Abuse policy updated March 2015; ADM-VI-06, RCSM-L-10 which stated the individual receiving the report of alleged abuse or neglect is to notify the Director of Care (DOC) or designate (or if after hours, the senior manager on call) immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse, neglect and initiate the investigation.

The policy also states the substitute decision maker or person requested by the resident of the incident if the resident is harmed, and within 12 hours for all other situations of alleged or witnessed abuse or neglect.

Inspector #622 interviewed Registered Nurse (RN) Manager #137 who stated the homes expectation is for the Registered Nurse to report incidents of actual or suspected abuse or neglect to the Director of Care. RN #137 stated PCP staff #138 had reported to her during the middle of the night the incident which occurred on the specified date. RN #137 stated she had not called the on call duty manager because it was in the middle of the night and nothing further could be done at that time. RN #137 stated she placed a note either under the Director of Care's door or in her communication file.

According to the Critical Incident Report, the Power of Attorney was not notified of the incident until 25 days after it occurred. [s. 20. (1)]

3. The following is related to log #020052-15:

On a specified date RN #S128 was notified by PCP #S139 that resident # 050's brief was not changed all shift. At the time RN #S128 was notified it was the end of the 1500-2300 hrs shift. RN #S128 immediately ensured that resident #050 was changed.

RN #S128 wrote an email addressed to DOC #S107 on the same specified date at 0200 hrs indicating among other concerns that resident #050 was not changed the entire shift. A Critical Incident was submitted on the same date at 1636 hrs.

RN #S128 indicated during an interview with Inspector #541 that she would consider the identified concern to be an allegation of neglect. DOC #S107 also indicated during an interview with Inspector #541 that this situation would be considered resident neglect. RN #S128 further stated that upon becoming aware of an alleged or witnessed allegation of abuse and/or neglect, the home's process to ensure the Director is immediately notified is for the RN to call the on-call manager who then notifies the Director.

RN #S128 indicated to Inspector #541 she did not call the on-call manager in this situation as she believed she had dealt with it appropriately and there was no risk to the resident.

Abuse policy # ADM-VI-06, RCSM-L-10 states that the individual receiving the report of alleged abuse or neglect is to notify the Director of Care (DOC) or designate (or if after hours, the senior manager on call) immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse, neglect and initiate the investigation.

The policy further states that the same individual is to immediately notify the resident's substitute decision maker or person requested by the resident of the incident if the resident is harmed, and within 12 hours for all other situations of alleged or witnessed abuse or neglect.

Inspector #541 asked the home to provide documentation that resident #050's SDM was notified upon becoming aware of the neglect that occurred on the specified date. Inspector was provided with a note indicating the SDM was notified five days after the neglect was alleged to have occurred.

The home's abuse policy was not followed as RN #S128 did not immediately notify the on-call manager and therefore the Director was not immediately notified of an allegation of resident neglect and resident #50's SDM was not notified within the time period stated in the home's policy. [s. 20. (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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a documented record was kept in the home related to a resident concern about the operation of the home specific to meal times.

During an interview with Resident #037 he/she indicated that on a specified unit the breakfast and lunch meals are served later than their scheduled time of 0900 and 1230 hours.

Resident #037 stated that he/she used to go to Residents' Council with this issue but felt nothing was done to rectify the problem.

Upon review of the Food Committee Meeting Minutes from a specified date, there is a note that a resident from resident #037's unit expressed frustration about food service not starting at the right time at breakfast and lunch. Nursing staff are not ready for service at 9am and 1230 pm. The meeting minutes indicated that the time line for this concern was "ongoing" and the Food Service Manager/DOC were responsible for follow-up.

The next Food Committee Meeting Minutes from two months following the initial concerns do not mention anything about this Resident's concern or what follow-up action was taken.

The Director of Care #107 indicated in an interview that she was unaware of the issue brought forward by Resident #037. She called the retired Food Service Manager (FSM)

who was in place at the time of the meeting when the initial concerns were brought forward, who indicated that she did follow-up with the Resident but did not feel the concern was founded. The Director of Care could not provide any documentation related to the type of action that was taken by the FSM in response to Resident #037's complaint, the final resolution (if any), or the date/response made to the resident. [s. 101. (2)]

2. The following is related to log #030524-15:

On a specified date the Director received a complaint from a resident's Power Attorney (POA) stating that the resident's electric wheelchair had been taken away and replaced with another one that doesn't fit. The POA stated they had not been informed about the change of the wheelchair or why it was exchanged. The POA stated the resident does not fit the wheelchair properly and has fallen six times on outings. The POA stated the home does not notify them when the resident has appointments and when incidents occur, that they have left several messages for the Director of Care on four specified dates but never received a call back.

Inspector #622 reviewed the progress notes by staff #141 from a specified date which revealed the Power of Attorney requested to speak with the Director of Care. Staff #141 sent an email to the Director of Care #131 on the same date to notify her.

Inspector #622 reviewed the progress notes by RN #127 from a specified date which revealed RN #127 spoke with the Power of Attorney who requested to speak with the Director of Care the following Friday after 1400 hours, the RN sent an email to the Director of Care #131.

Inspector #622 reviewed the home's policy on complaints Index I.D. # DM-VI-18 which states; the manager will investigate, resolve and follow-up with the complainant. The manager is responsible for keeping all investigation and follow up related to complaints in his or her office or on the residents electronic health record.

Inspector #622 interviewed Director of Care #131 who stated she always calls the Power of Attorney (POA) for resident #052 back when she receives calls from them and if not able to reach the POA, she will leave a message with the date and time she called them. She revealed she was not sure if she kept a log of these calls or not but would look and see.

On the following day Inspector #622 interviewed Director of Care # 131 who stated she had not kept a log of the calls she made to the Power of Attorney.

Inspector #622 reviewed the complaints binder from the time period during which the complaints were made which did not contain any documentation in reference to complaints for this resident, brought forward by the POA September 7, 17, 21, 27, 2015.

Inspector #622 reviewed the progress notes from the time period during which the complaints were made and noted there was no documentation of conversations between the Director of Care #131 and the Power of Attorney as follow up to concerns raised for the three specified dates. [s. 101. (2)]

***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 documented record was kept in the home related to a resident concern about the operation of the home specific to meal times, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD**

**Specifically failed to comply with the following:**

**s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,**
**(a) is well maintained; O. Reg. 79/10, s. 111. (2).**
**(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).**
**(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure resident #018's PASD was properly applied.

Resident #018 has physical impairments and difficulty communicating. On a specified date, the resident was observed seated in a wheelchair with a right leg extender and was wearing a backward latching seat belt. The belt was noted to be loose and could be pulled away from the resident's abdomen seven inches. The resident was asked if he/she could remove or adjust the belt on his/her own and indicated he/she could not using hand/arm gestures.

PSW #S100 was asked to check #018's seat belt. She indicated the belt was fine and the resident did not like it to be tight. She also indicated the resident rarely tries to get up from the chair on his/her own.

RPN #S103 was informed that resident #018's seat belt was very loose and that the PSW had indicated it was properly applied in accordance with the resident's wishes. The RPN was asked to assess the seat belt but stated she was unfamiliar with this resident unit and indicated the PSWs know the residents well. She further stated if the PSW felt the belt was properly applied, it is fine. The RPN did not assess the application of the seat belt.

The following day, resident #018 was observed seated in the wheelchair with the backward latching seat belt. The belt was noted to be properly applied at this time. PSW #100 was asked about the application of the belt and indicated the resident wanted the belt to be applied tighter today.

The manufacturer's instructions titled "Application Instruction Sheet Posey Lap Belt/Padded Lap Belt" were reviewed and indicated, on page 2:
-Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient.
-Loose straps may allow the patient's body to slide forward, or down in a chair and become suspended in the restraint, resulting in chest compression and suffocation.

RN Manager #S105 was interviewed and indicated the resident's seat belt had been assessed as a PASD to ensure proper positioning in the wheelchair and to prevent falls. RN #S105 agreed that at no time would it be acceptable to apply an improperly fitted seat belt due to the risk of strangulation. [s. 111. (2) (b)]

***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 Every licensee shall ensure that a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Re: Log# 020124-15
On July 26, 2015 PCP #S121 was assisting resident #020 on the commode at the resident's bedside. During the home's investigation, PCP #S121 indicated resident #020's seat belt was initially applied but was removed to complete an aspect of care. Resident #020 was demonstrating some behaviors and PCP #S121 left the room to get help. PCP #S121 indicated she forgot to re-apply resident #020's seat belt prior to leaving the room. Resident #020 was upset at not having the seat belt applied and informed a family member of what had occurred.

Resident #020's plan of care in effect at the time of the incident has the following intervention under the focus for toileting:
"Black seat belt to be applied for safety while on commode as per resident's preference (resident able to remove belt independently)"

PCP #S121 failed to ensure resident #020's seat belt was applied as outlined in the resident's plan of care. [s. 6. (7)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:

(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
(b) complied with

Under O.Reg 79/10 s. 48(1) 2 Every licensee of a long-term care home shall ensure that the interdisciplinary programs are developed and implemented in the home, a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Re: Log# 022620-15

On a specified date resident #056 went to hospital to have a procedure related to skin care. Upon review of resident #056's progress notes from the date of the procedure up to the following 11 days, there was no documentation regarding the resident's follow-up care related to the procedure done on the specified date. There were also no progress notes reflecting that resident #056 had this procedure done on the specified date. The home's skin and wound care coordinator did not assess the resident until 12 days following the procedure as he/she was not notified until 10 days following the procedure. During the home's investigation into the incident, RPN #S102 was interviewed and it was determined the RPN did not obtain follow-up instructions from the resident's POA when he/she accompanied resident #056 to the home following the procedure. As a result, there was no documented assessment regarding resident #056's skin until twelve days following the procedure.

Inspector #541 obtained the home's skin and wound policy #RCSM-C-30 titled Skin and Wound Program.

Under the heading Responsibilities – RPN, policy #RCSM-C-30 states:
1. Two assessments will be completed for each resident as per the following:
Braden scale assessment in PCC which will indicate a risk score of low/moderate/high, the Braden Scale is to be completed:
I. On Admission
II. Quarterly
III. A change in the resident's status eg. palliative, no longer weight bearing, decrease in mobility, etc
IV. As needed

Make referral to the Wound Care Coordinator for residents with a risk score of Moderate

or High;

Skin and Wound assessment in PCC for the following residents;
I. within 24 hours of the resident's admission
II. upon any return of the resident from hospital
III. upon any return of the resident from an absence of greater than 24 hours;
IV. A change in the resident's status eg. palliative, no longer weight bearing, decrease in mobility
V. Quarterly

4. Provide wound care as per RNAO BPG and Arbour Heights policy and procedures. Complete Braden Scale assessment in PCC for all new admissions, quarterly and when any resident has a change in status and as needed.

5. Ensure residents with altered skin integrity receive immediate treatment and interventions to reduce or relieve pain, promote healing, prevent infection as required.

DOC #S117 was interviewed by Inspector #541 and she indicated that the expectation upon return from hospital following a procedure such as the one resident #056 received, would be for the registered nursing staff to assess the resident.

The home failed to policy# RCSM-C-30 by not assessing or providing any interventions for resident #056's skin for 12 days following the procedure. [s. 8. (1) (a),s. 8. (1) (b)]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs stored in a medication cart was secured and locked.

On December 14, 2015 at approximately 0900 hour, during the initial tour of the home, this inspector observed an unlocked medication cart on Smuggler's Cove. The cart was in the hallway outside of resident room #320. The inspector remained in the hallway in the vicinity of the cart for greater than three minutes before observing the registered staff member exiting a resident room from down the hall. The unlocked medication cart was not within the registered staff's sight and residents were in the area of the medication cart at the time of the observation.

On December 15, 2015 at approximately 0820 hour, the inspector observed an unlocked medication cart on Confederation Park in the hallway outside of resident room #110. The registered staff member was observed leaving the cart to deliver medications to a resident room at the far end of the hallway. The unlocked medication cart was left unattended and out of the sight of the registered staff for greater than four minutes. Several residents were seated in the area of the medication cart at this time while waiting to enter the dining room.

The medications in the medication cart were not secured in a safe manner when staff was not present. [s. 129. (1) (a)]

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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

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**Issued on this 14th day of January, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | AMBER MOASE (541), DARLENE MURPHY (103), HEATH HEFFERNAN (622), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY BROWN (602) |
| **Inspection No. / No de l'inspection :** | 2015_280541_0041 |
| **Log No. / Registre no:** | 033664-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jan 14, 2016 |
| **Licensee / Titulaire de permis :** | 2109577 ONTARIO LIMITED<br>195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5 |
| **LTC Home / Foyer de SLD :** | 2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS<br>564 Tanner Drive, KINGSTON, ON, K7M-0C3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Christine Sellery |

To 2109577 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

**Order / Ordre :**

The licensee is hereby ordered to:

- remove all unlabeled nail care equipment and unlabeled personal items from all showers and tub rooms,

-update policy, "Nail Clipping Devices", INF-II-89 to include the steps required to effectively clean and disinfect all nail care equipment and to identify the high level disinfectant that will be used.

-ensure all direct care staff receive education to include the following at a minimum:
-the updated "Nail Clipping Devices" policy
- the cleaning and disinfecting of nail care equipment using a high level disinfectant,
-the use of resident labeled and dedicated nail care equipment for routine nail care and,
-the importance of not sharing personal items such as hair brushes and combs.

**Grounds / Motifs :**

1. The licensee has failed to ensure all staff participate in the implementation of the infection prevention and control program.

On December 14, 2015, Inspector #103 conducted a full walking tour of the home that included shower and tub rooms. The following observations were made during the tour:

-MacDonald tub room at 0840 hour-two small unlabeled pairs of nail clippers

were noted in a white basket in top drawer-one pair was noted to be soiled,

-MacDonald shower room at 0845 hour-one pair of unlabeled, soiled nail clippers was observed on the counter beside the sink,

-Smugglers Cove tub room at 0850 hour-one unlabeled black brush with hair and one used, unlabeled deodorant was observed on the counter; one unlabeled black comb with dander evident was found in the drawer,

-Breakwater shower room at 0915 hour-one pair of soiled unlabeled nail clippers with nail clippings present was observed and two pairs of soiled nail nippers were in a basket on counter,

-Portsmouth shower room at 0935 hour- unlabeled, soiled large nail clippers were observed on the shower wall with nail clippings evident, a large pile of used towels were piled on the floor to the left of the doorway and several used towels and used, disposable gloves were observed on the floor; the shower stall was noted to have three wet, used washcloths on the floor,

-At 1240 hour, the inspector returned to this shower room and observed 10+ soiled, wet facecloths on the floor of the shower stall; one cloth was orange and appeared to be soiled with feces; the unlabeled large nail clipper was still present on shower wall with nail clippings evident,

-Portsmouth tub room at 0940 hour-one large pair of unlabeled nail clippers was found in the top right drawer and were noted to be dirty; second pair of unlabeled, large nail clippers were found in a blue basket next to the sink and were noted to be soiled with clippings,

-At 1245 hour the inspector returned to this area and observed one large and two small unlabeled nail clippers in the blue basket by the sink-all appeared soiled and the large pair had evidence of nail clippings,

-City Park shower at 0950 hour was observed to have one unlabeled, soiled pair of small nail clippers stored with emery boards that appeared to be new/ unused,

-City Park tub room at 1000 hour-one unlabeled black brush with hair evident was observed in top drawer and three black unlabeled combs with dander in

them observed in left top drawer.

On December 16, 2015 the following observations were made:
-Portsmouth shower room-dirty nail clippers were found on ledge of shower-nails still evident in the clippers; clippers were also noted to have some rusting evident; these nail clippers were observed in same location during initial tour of the home two days ago,

-Portsmouth tub room-dirty large and small nail clippers were found in top right drawer and in a blue basket by the sink; a white, unlabeled hair brush with hair evident was also found in this drawer,

-MacDonald spa room-visibly soiled, large nail clippers on counter by sink and a second pair on white storage unit, visibly soiled with nails,

-MacDonald tub room-1 small used/soiled nail clippers were observed,

-City shower room-visibly dirty pair of small nail clippers found in basket sitting beside an unlabeled used hairbrush with hair visible.

The Administrator was asked to observe the Portsmouth shower and tub room following the inspector's observations. The Administrator confirmed the presence of the soiled and unlabeled nail clippers and the apparent sharing of brushes/combs. The inspector stated similar findings had been observed in eight of the twelve shower/tub room areas.

Personal Care Providers (PCPs) were interviewed from various resident areas and indicated each resident should have labeled nail care equipment that is to be used specifically for their individualized nail care needs and that personal items such as combs and brushes should be labeled and not shared.

The home's Infection Control lead RN #S105 was interviewed and indicated all residents are to have dedicated, labeled nail care equipment that is to be stored at the bedside. She further indicated the nail care equipment should be promptly cleaned and disinfected after use and returned to the bedside and should not be left in the shower/tub room areas. RN #S105 was unable to explain why the large and small soiled nail clippers would be found in the shower/tub rooms and was unlabeled.

RN #S105 indicated the nail nippers that were observed in the Breakwater shower room would be considered shared resident nail equipment as not all residents would require this type of equipment for foot care but would be required for some. RN #S105 indicated shared resident care equipment such as nail nippers would be cleaned and disinfected using Virex II 256 in accordance with the instructions on the bottle.

The inspector was provided with policy, "Nail Clipping Devices", INF-II-89. Under procedure, it indicated:
-remove visible soil
-follow manufacturers guidelines for the disinfectant cleaner (Virex II 256).

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in all Health Care Setting, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices which include nail/foot care instruments indicates the need for meticulous cleaning of nail clippers followed by a high level disinfectant. Virex II 256, which is currently being used by this home, is a hospital grade disinfectant, not a high level disinfectant and therefore is not an effective disinfectant for shared nail care equipment.

The compliance history of the home related to Infection Prevention and Control was reviewed for the past three years and the home was issued a Written Notification (WN) in December 2014 for related infection control issues. The scope of this non-compliance was assessed as widespread (eight of the twelve shower and tub rooms were affected) and the severity was assessed as potential for harm to the residents. As a result, a compliance order will be issued. (103)

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

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee is ordered to:

Ensure all Personal Care Providers (PCPs) receive education and as needed, re-education on the home's Safe Transferring policy.

Develop and implement a monitoring system to be implemented by registered staff to ensure safe transferring techniques are being used by all PCPs when a resident requires a two person transfer.

Outline the action to be taken to address the further learning needs of PCPs not following the policy.

**Grounds / Motifs :**

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The following is related to log #020052-15:

A Critical Incident (CI) report was submitted by the home for improper/incompetent treatment of a resident that results in harm or risk to a resident on a specified date. According to the CI report, the home received a letter written by RN #S128 indicating that PCP #S130 had transferred resident #049 by himself on a specified date when the resident was to have a two-person transfer.
The plan of care for resident #049 in effect on July 28, 2015 indicates the resident requires a mechanical lift with 2 staff for transferring.

RPN #S129 was interviewed and confirmed that PCP #S130 also completed an independent transfer of resident #051 with a mechanical lift on another specified date. RPN #S129 states she provided a supervisory feedback form on the date of the first unsafe transfer to PCP #S130 for transferring by himself using a mechanical lift. Inspector #541 reviewed the supervisory feedback form and noted it was signed by PCP #S130 the day prior to completing the second unsafe transfer.

It was noted by Inspector #541 that neither resident #049 or #051 were injured as a result of the improper transfers.

The care plan for resident #051 in place at the time of the unsafe transfer indicates the resident uses a ceiling lift with 2 staff for transferring.

According to the home's investigation in to the incident, PCP #S130 indicated being aware resident #051 and #049 require two staff for transfers however PCP #130 did the transfers on his own as he did not want to wait for assistance by another staff member.

PCP #S130 was disciplined as per the home's human resources procedures for completing two-person and mechanical transfers independently.

PCP #S130 failed to use safe transferring techniques when he transferred residents #049 and #051 by himself using a mechanical lift when both residents required two staff members to safely transfer. [s. 36.]
(541)

2. Staff did not use safe transferring techniques when assisting Resident #050 to the toilet as per the residents prescribed two person transfer status.

The following is related to log #021244-15.

On a specified date and time, Resident #050 was found by a PCP staff sitting on the floor beside the toilet in the bathroom. The resident was unable to remember if he/she was assisted to the bathroom or if he/she attempted to go independently. The home's investigation that day revealed that the night shift PCP #S126 completed a one person transfer to toilet resident #050 near the end of the night shift and left the resident sitting on the toilet with the call bell in reach. PCP #S126 advised that this was reported to the day staff prior to her

departure that morning.

The care set out in resident #050's plan of care indicates that the resident was a two person transfer at the time of the incident and that the resident required supervision while on the toilet.
Notes from the subsequent meeting with the DOC and PCP #S126 indicate that the PCP advised that she neglected to look at the transfer logo. PCP #S126 was disciplined as per the home's human resources procedures. [s. 36.]
(602)

3. The licensee has failed to ensure that safe transferring techniques were used when assisting residents.

The following finding is related to log 018657-15:

A critical incident report was submitted by the home indicating that on a specified date, PCP #S123 attempted to independently transfer Resident #046 from the wheelchair to the commode. During the transfer, PCP #S123 stepped away from the resident to move the wheelchair when the resident fell backward into the door frame and sustained an injury.

Resident #046's care plan at the time of the fall indicated that the resident requires extensive assistance from two staff for toileting and transfers.

Interviews with RPN #S124 and DOC #S107 confirmed that PCP #S123 knew that Resident #046 was a two-person transfer and had received training related to safe transfers prior to the incident.

PCP #S123 was disciplined as per the home's human resources procedures. [s. 36.]

The severity of this non-compliance was assessed as actual risk due to resident #046 sustaining an injury as a result of a fall caused by unsafe transferring techniques. The scope of the issue was assessed as pattern as three critical incidents were submitted for three separate occasions where a PCP unsafely transferred residents resulting in either harm or risk of harm to the residents. As a result, a Compliance Order is warranted. (197)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

**Order # / Ordre no :** 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. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

**Order / Ordre :**

The licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair by correcting the following deficiencies:
- Loose, broken and jagged areas of doors, walls and trim
- All wall areas where metal strapping is exposed

The licensee must ensure that the maintenance program is organized and effective in
meeting the overall maintenance needs of the home, with written schedules and procedures for remdedial maintenance.

The licensee must develop and implement an effective system of ongoing monitoring to
ensure that all maintenance issues are corrected promptly.

**Grounds / Motifs :**

1. The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
During the stage one observations, the following observations were made by the inspectors:

-Resident #005 Deep gouges down to metal strapping/drywall is rough and protruding at corner by closet, long areas of black marks/scrapes along wall as

you enter the room, scrapes in surface on lower edge of closet doors, (541)

-Resident #006 Deep/rough gouges at corner by bathroom and numerous gouges in wall beside closet, (541)
-Resident #010 Deep gouges on the wall corner by the bathroom and closet, surface on lower edge of closet doors are scraped, vent in the bathroom has obvious dust/dirt evident, (541)

-Resident #011 Deep gouges on wall by bathroom door and by bed; one of the closet doors has an open break in the surface along the entire width/surface is not intact, (541)
-Resident #012 Deep gouge and rough surface at corner wall, numerous areas of disrepair to surface at closet wall corner, bottom of bathroom door trim is loose, jagged and protruding, vent in the bathroom has obvious dust/dirt evident, (541)

-Resident #013 Wall in resident's room outside bathroom is scraped with black marks, some pieces of drywall missing, (541)

-Resident #015 Edge of bathroom door is loose, broken and jagged, (103)

-Resident #017 Edge of door frame on bathroom door is broken and loose; corner of bathroom door has missing baseboard-rough area, (103)

-Resident #018 Large areas of unpainted repair on wall by bed and bathroom; appears re-damaged in some areas-especially at corners- deep gouges, baseboard and trim at bathroom are missing; lower edge of closet is scraped/paint missing; areas also present on wall at end of bed; bathroom also has large areas of disrepair; some repaired and re-damaged, (103)

-Resident #019 Scarring on bottom of closet and bathroom doors; bathroom door frame is loose and very sharp; resident states she has hurt her ankle on it before; patched hole in ceiling/rough/unfinished; ceiling vent in bathroom is very dirty with obvious dust/dirt, (103)

-Resident #020 Large areas of disrepair where new spackle has been applied but not yet painted at the corner by closet- areas have been re-damaged since repaired; closet is scraped at base and trim at bottom left is pulled away/sticking out; large areas of gouges in bathroom as well; new spackle applied/not yet

painted and re-damaged; bathroom door trim is loose at bottom edge of door and jagged, (103)

-Resident #021's room was observed to have a deep gouge in the corner by closet which are rough and jagged to touch; scrapes are noted across lower end of closet doors; there are numerous gouges in the wall at the end of bed and numerous scrapes on the wall in bathroom, (103)

-Resident #023 Small area where corner is gouged at closet; scarring of finish at base of closet and bathroom door, (103)

-Resident #026 Wall beside head of bed has numerous deep gouges in it; surface paint missing and it is rough to touch, (103)

-Resident #027 Deep gouge in wall beside closet, (103)

-Resident #030 Numerous deep gouges at closet wall by resident's bed, (197)

-Resident #031 Wall to the left as you enter room has deep gouges down to metal strapping at corner; orange sized hole in the wall observed beside the closet door, several indentations along wall next to toilet, (197)

-Resident #038 Scuffs on wall as you enter room; paint is scraped and areas where finish is missing/gouged; several gouges noted by closet; area of drywall repaired but unpainted next to toilet paper holder, (197)

-Resident #011 Deep gouges on wall by bathroom door and by bed; one of the closet doors has an open break in the surface along the entire width/surface is not intact, (197)

-City Park shower room-observed to have several areas of disrepair on walls; areas noted where metal stripping is exposed in some areas and missing wall tiles at corners, (103)

-MacDonald Park shower room-disrepair noted -deep gouges in wall at chair height, (103)

-Breakwater tub room- deep gouges in wall near garbage/linen carts (103)

The Environmental Supervisor #106 was interviewed in regards to the home's process for addressing disrepair. He stated the home fully paints and repairs all resident rooms when the residents are discharged. #106 indicated that painting and repairs to drywall for occupied rooms are not addressed on a regular basis and only if an extreme case. He also stated the home has a computerized means of requesting all repairs including painting and repairs. According to #106, any staff member can request repairs to be completed when it is identified.

The severity of the disrepair was assessed to be actual as resident #019 indicated to this inspector that he/she has scraped his/her ankle/foot on the jagged bathroom door frame in the past. The scope of the disrepair was noted to be widespread as it was observed on each of the resident units throughout the home. The home has no plan in place at this time to address the disrepair outside of resident rooms upon discharge. As a result, a compliance order will be issued to address this non-compliance. (103)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 13, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 14th day of January, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amber Moase

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office