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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 01, 2021	2021_738753_0004 (A1)	022911-20, 022926-20, 023662-20, 023665-20, 025797-20, 025896-20, 025968-20, 026042-20, 000177-21, 000622-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

Amended by KATHERINE ADAMSKI (753) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

This public inspection report has been revised to reflect the extended compliance due date and correction to findings.

The Complaint inspection [#2021_738753_0004] was completed on January 25 - 29, February 1 - 5, 8 - 12, 15 - 19, 2021.

A copy of the revised report is attached.

Issued on this 1 st day of April, 2021 (A1)

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 01, 2021	2021_738753_0004 (A1)	022911-20, 022926-20, 023662-20, 023665-20, 025797-20, 025896-20, 025968-20, 026042-20, 000177-21, 000622-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

Amended by KATHERINE ADAMSKI (753) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 25 - 29, February 1 - 5, 8 - 12, 15 - 19, 2021

The following intakes were completed during this Complaint Inspection:

Log #022911-20, #022926-20, and #023662-20 related to abuse and neglect

Log #025797-20 and #000177-21 related to nutrition and hydration

Log #025896-20, #025968-20 related to medication administration and skin and wound concerns

Log #023665-20 related to proper transferring techniques

Log #026042-20 related to medication administration

Log #000622-21 related to personal support services

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Public Health Representatives, RAI MDS Co-Ordinator, Environmental Services Manager (ESM), Program Manager, Skin and Wound Care Lead, Registered Nurses (RN), Registered Dietitian, Registered Practical Nurses (RPN), residents, Director of Care Clerk (DOC Clerk), Personal Support Worker (PSW), Health Care Aides (HCA), Housekeeping, and Laundry Aides.

Observations were completed of residents and staff to resident care provision. Review of relevant documentation was completed.

PLEASE NOTE: This inspection was conducted concurrently with critical

incident inspection #2021_738753_0005 and follow-up inspection 2021_738753_0003. A Written Notification and Compliance Order related to O. Reg. 79/10, s. 50. (2)(b)(ii), was identified in this inspection (Log #025896-20, #025968-20) and will be issued in follow-up inspection #2021_738753_0003.

The following Inspection Protocols were used during this inspection:

Dining Observation
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

7 WN(s)
4 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 protect a resident from neglect by staff.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care services, or assistance required for health safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg.

79/10, s.5.

a) A resident was not provided treatments and other care for their wounds over several days.

b) A resident was not administered their medications as prescribed which resulted in poor symptom management and this negatively impacted their quality of life. Despite the resident calling for help, staff did not provide care to the resident. The resident's medical condition deteriorated requiring further invasive treatments.

Sources: progress notes, TAR December 2020, MAR, the home's investigation notes of a complaint, an interview with the complainant and the DOC. [s. 19. (1)]

2. The licensee has failed to protect a resident from emotional abuse by staff members.

For the purpose of the definition of "emotional abuse" in subsection 2 (1) of the Act, emotional abuse is defined as any threatening insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident was emotionally abused by staff.

a) Staff turned the resident's call bell off and told them in a rude tone to stop calling. The resident was experiencing pain and requested assistance through the call bell multiple times. The resident was assessed for pain and received medication only after their family member notified the registered staff.

There was actual emotional harm to the resident as a result of staff not providing care in a timely manner when the resident first expressed pain.

b) Staff spoke loudly and inappropriately in front of the resident. The staff's tone of voice was rude and angry when they spoke and the resident appeared frightened and emotional, saying they were going to die the next day. Documentation showed that the resident's demeanor and usual behaviour were negatively impacted after the incident occurred.

The staff's inappropriate conversation outside of the resident's room and their

loud, angry and frightening tone of voice caused distress to the resident and fear to call for assistance.

Sources: The home’s investigative notes, three video surveillance records, progress notes, call bell history report, and interviews with the complainant and staff. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 :

The licensee has failed to ensure that two staff members used safe transferring techniques when assisting two residents.

a) Staff used the wrong lift to transfer a resident, which put the resident at risk of injury.

Sources: observations of the resident, care plan, safe lift transfer assessment, interviews with staff. [s. 36.]

b) Staff used an inappropriate transfer technique to transfer a resident, which put the resident at risk of injury.

Sources: the home's investigative notes, video recordings, care plan, physiotherapist assessment, and interviews with staff. [s. 36.]

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 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 the Food and Fluid Intake Monitoring policies and procedures included in the Nutrition and Hydration Program were complied with, for a resident.

The Long Term Care Home Act s. 11 (1)(a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

Ontario regulation (O. Reg.) 79/10, s. 68 (1)(b) and s. 68 (2) requires that the program includes the development and implementation of policies and procedures related to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the home’s policy and procedure "Food and Fluid Intake Monitoring", last reviewed December 2019.

The home's Food and Fluid Intake Monitoring policy and procedure directed nursing/interdisciplinary staff to review intake records on a daily basis, complete a referral to the Registered Dietitian (RD)/designate if a resident had demonstrated a significant change in their normal intake pattern, jointly review any residents with changes from their normal intake patterns with the resident or their Substitute Decision Maker (SDM) and discuss interventions.

A resident's intake records showed they had reduced intake compared to their normal intake pattern for several days prior to a referral being sent to the RD. A referral to the RD should have been made after the resident experienced three days of reduced intake.

The resident's SDMs stated they had not been made aware of the resident's reduced intake until the resident's weight was negatively impacted.

There was actual harm experienced by this resident resulting from the licensee not implementing interventions for the resident's reduced intake in a timely manner.

Sources: Interviews with the complainant and staff, the resident's assessments, progress notes, intake records, Extendicare's Nutrition and Hydration policy and procedure (last reviewed December 2019). [s. 8. (1) (a),s. 8. (1) (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 to ensure the Food and Fluid Intake Monitoring policies and procedures included in the Nutrition and Hydration Program are adhered to for residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received nail care, including the cutting of fingernails.

A complaint was submitted related to the length of a resident's fingernails.

Staff stated that the resident's nails were trimmed on shower days, however the inspector observed on several occasions that the resident's nails remained long despite having had a shower the previous evening.

There was risk of harm to a resident as a result of their fingernails not being trimmed because long fingernails can harbour bacteria, and the resident may have accidently scratched themselves.

Sources: observations of a resident, interviews with the complainant, resident and staff, the resident's electronic records including task documentation survey reports. [s. 35. (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 residents receive hygiene care including fingernail trims, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a weight monitoring system was in place to measure and record a resident's monthly weight.

A review of a resident's weight records showed that a monthly weight had been missed. There were no progress notes documenting that the resident had refused to be weighed.

The home's Height and Weight Monitoring policy (December 2019) directed care staff to weigh residents ideally on the first scheduled bath/shower of the month, and for the nurse to ensure that a current, accurate weight of the individual resident was recorded by the tenth day of each month either on paper or electronically and entered in the resident's health care record.

A resident experienced significant weight loss around the time that their weight had been missed.

There was risk of harm to the resident resulting from the resident's weight not being measured.

Sources: Height and Weight Monitoring policy (last reviewed December 2019), the resident's progress notes and weight records, and interviews with the RD and other staff. [s. 68. (2) (e) (i)]

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 weight monitoring system is in place to measure and record residents' weight monthly, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was administered their medications as prescribed.

A resident was to be provided with scheduled medications. The home's investigation determined the registered staff did not administer the medications because they could not locate one of the medications. The staff members did not access the home's emergency drug box to provide the resident with their prescribed medications.

The resident not having received their scheduled medications resulted in their symptoms not being managed and having a negative impact on their quality of life.

Sources: The resident's medication administration records, the home's investigation notes of a complaint, interview with the complainant and DOC #101.
[s. 131. (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 residents are administered their medications as prescribed, 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 an incident of abuse which resulted in harm to a resident was immediately reported to the Director.

A Critical Incident System (CIS) report was submitted to the MLTC regarding an incident of verbal and emotional abuse of a resident by a staff member.

The incident should have been reported immediately to the Director, but it was not reported until one day later.

Sources: CIS report, the home's investigative notes, resident #001's progress notes, interview with the DOC and other staff. [s. 24. (1)]

Issued on this 1 st day of April, 2021 (A1)

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

Original report signed by the inspector.

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KATHERINE ADAMSKI (753) - (A1)
Inspection No. / No de l'inspection :	2021_738753_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022911-20, 022926-20, 023662-20, 023665-20, 025797-20, 025896-20, 025968-20, 026042-20, 000177-21, 000622-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 01, 2021(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Braic

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001 **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.

Specifically, the licensee must ensure:

a) The identified residents are free from abuse and neglect by anyone.

b) Staff #133 is re-trained on the home's prevention of abuse and neglect policy. A written record must be kept of the education that includes who completed the training, the content, and date staff sign off.

c) Staff #137 is re-trained on the home's medication administration policy. A written record must be kept of the education that includes who completed the training, the content, and date staff sign off.

d) All staff on Ballinafad are re-trained on taking appropriate action with responding to resident call bells. A written record must be kept including who completed the training, the content, and date staff sign off.

e) All agency staff have completed education and training related to the home's prevention of abuse and neglect policy within one week of beginning to work in the home. A written record must be kept including who completed the training, the content, and date staff sign off.

Grounds / Motifs :

1. The licensee has failed to protect a resident from neglect by staff.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care services, or assistance required for health safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s.5.

a) A resident was not provided treatments and other care for their wounds over several days.

b) A resident was not administered their medications as prescribed which resulted in poor symptom management and this negatively impacted their quality of life. Despite the resident calling for help, staff did not provide care to the resident. The resident's medical condition deteriorated requiring further invasive treatments.

Sources: progress notes, TAR December 2020, MAR, the home's investigation notes of a complaint, an interview with the complainant and the DOC. [s. 19. (1) (694)

2. The licensee has failed to protect a resident from emotional abuse by staff members.

For the purpose of the definition of "emotional abuse" in subsection 2 (1) of the Act, emotional abuse is defined as any threatening insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident was emotionally abused by staff.

a) Staff turned the resident's call bell off and told them in a rude tone to stop calling. The resident was experiencing pain and requested assistance through the call bell multiple times. The resident was assessed for pain and received medication only after their family member notified the registered staff.

There was actual emotional harm to the resident as a result of staff not providing care in a timely manner when the resident first expressed pain.

b) Staff spoke loudly and inappropriately in front of the resident. The staff's tone of voice was rude and angry when they spoke and the resident appeared frightened and emotional, saying they were going to die the next day. Documentation showed that the resident's demeanor and usual behaviour were negatively impacted after the incident occurred.

The staff's inappropriate conversation outside of the resident's room and their loud, angry and frightening tone of voice caused distress to the resident and fear to call for assistance.

Sources: The home's investigative notes, three video surveillance records, progress notes, call bell history report, and interviews with the complainant and staff. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was actual harm to the residents related to the abuse and neglect they experienced.
Scope: There was a pattern of non-compliance because two of three residents reviewed were impacted.
Compliance History: The licensee's compliance history includes one previous compliance order (CO) to the same section, and 15 unrelated COs in the past 36 months.

(758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2021(A1)

Order # / No d'ordre: 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 must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must ensure:

a) That all staff use safe transferring devices or techniques when assisting resident's.

b) That three identified staff are re-educated on safe transferring techniques and mechanical lifts use. A written record must be kept of the education that includes who completed the training, the content, and date staff sign off.

Grounds / Motifs :

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

Staff used the wrong lift to transfer a resident, which put the resident at risk of injury.

Sources: observations of the resident, care plan, safe lift transfer assessment, interviews with staff. [s. 36.]
(758)

2. Staff used an inappropriate transfer technique to transfer a resident, which put the resident at risk of injury.

Sources: the home's investigative notes, video recordings, care plan, physiotherapist assessment, and interviews with staff. [s. 36.]

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents resulting from improper transferring techniques.
Scope: There was a pattern of non-compliance because two out of three residents reviewed were impacted.
Compliance History: The licensee's compliance history includes two previous voluntary plans of correction (VPC) and two written notifications (WN) to the same section. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2021

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:

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

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 1 st day of April, 2021 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by KATHERINE ADAMSKI (753) - (A1)

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

Service Area Office / Bureau régional de services : Central West Service Area Office