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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie 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
Mar 2, 2022	2022_595110_0003	015312-21, 016095-21	Complaint

Licensee/Titulaire de permis

Mon Sheong Foundation
36 D'Arcy Street Toronto ON M5T 1J7

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

Mon Sheong Scarborough Long Term Care Centre
2030 McNicoll Avenue Scarborough ON M1V 5P4

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

DIANE BROWN (110)

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): February 3, 4, 8, 9, 10, 11, 14, 2022.

The following intakes were inspected during this Complaint Inspection:

Logs #015312-21 and #016095-21 related to fall prevention concerns.

An Infection Prevention and Control Inspection was also conducted.

A Critical Incident System (CIS) inspection #2022_595110_0004 was conducted concurrently with this Compliant Inspection.

Note: Findings of noncompliance related to section 6.(7) of the LTCHA, 2007 and section 8.(1) of the Ontario Regulation 79/10, identified in concurrent CIS inspection #2022_595110_0004, were issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care, assistant Director of Resident Care, Registered Nurses, Registered Practical Nurses, Physiotherapist, Housekeeping aide, Administrator of StL imaging, Personal Support Workers, Family members.

During the course of the inspection, the Inspector toured resident home areas, conducted resident and infection control observations, reviewed clinical health records, reviewed video recordings, and reviewed relevant policies and risk management incident reports and audits.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

A Critical Incident was submitted to the Ministry of Long-Term Care reporting resident #001's fall.

An interview with the Personal Support Worker (PSW) who responded to the fall, described how they found the resident. The PSW's description revealed that the resident was not dressed by staff in dignified manner.

In follow-up the Inspector conducted random resident observations between 0648hrs and 0703hrs with PSWs and identified residents #002, #003, #004, #005 and #006 in bed also having been dressed by staff in an undignified manner.

The licensee failed to ensure the residents are dressed in a manner that respects their dignity.

Sources: PSWs #100, #103, #120 interviews and resident observations. [s. 3. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting resident #001's fall resulting in a significant change in status.

A record review and staff interviews revealed the resident was at risk of falling as they had had a prior fall before being admitted to the home.

At the time of the fall, a PSW heard and responded to the fallen resident. The staff described the resident's soiled clothing and the placement of their clothing. The PSW stated night staff, assist with dressing resident's prior to the end of their shift. An interview with the night PSW confirmed the manner in which the resident was dressed.

An interview with the Physiotherapist (PT) described resident #001 as being able to get up from their bed. The PT stated the dressing practice would restrict movement and was unsafe for this resident.

Interviews with RN #105 and the DRC confirmed awareness of the night staff practice of dressing residents and provided a shift report that documented education to discontinue this dressing practice. An interview with RN #015 confirmed that they had gone to each floor to educate night staff to stop the practice.

In follow-up the Inspector conducted random resident observations between 0648hrs and 0703hrs with PSWs and identified residents dressed in a manner that would restrice movement if they attempted to self-ambulate. The residents included #004 and #005, at risk of falling, according to their plan of care. A follow-up interview with the PT confirmed this practice for the identified resident's would be a safety concern as both residents could attempt self transferring and with their mobility restricted, by the placement of their clothing, increase their risk of falling.

Sources: observations, PSW, registered staff and PT interviews, progress notes, written plan of care. [s. 5.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting resident #001's fall resulting in their significant change of status.

At the time of the fall, a PSW heard and responded to the fallen resident. The staff described the fall resident including incontinence with wet clothing and brief .

The resident's plan of care identified the resident as using the toilet and requiring 1-2 staff with extensive assistance.

An interview with the night PSW revealed that they changed the resident's brief on the last round of their shift. The staff explained that the resident was awake but that they do not toilet residents on nights as there was only one staff. The full time day shift PSW confirmed the resident's brief was changed on nights and that the resident is not toileted until after breakfast.

An interview with a registered nurse (RN) confirmed the resident used the toilet, but stated seldom on nights do staff toilet residents because there was only one PSW. The RN further stated that some residents do not want to get up or their families would prefer they not get up to use the washroom. The RN stated they were unclear of the resident's toileting needs on nights from the plan of care.

The plan of care does not provide clear direction to staff, including agency staff, of the resident's toileting patterns and needs on days, evenings and nights.

Sources: Interviews with RN #102, RPN #104, PSWs #100 and #103. Progress notes, and written plan of care. [s. 6. (1) (c)]

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

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting resident #006's fall resulting in a significant change in status.

A record review identified the resident had two prior falls. One fall occurred when unexpected water was on the floor and the resident slipped and fell. The resident was later ordered an X-ray and pain medication as the resident complained of lower extremity pain.

The resident's plan of care, had a focus ' anticipating a need for pain relief', and was updated at the time of the X-ray and medication order. The interventions included directing registered staff to determine the appropriate pain management methods: analgesia(opioid/non-opioid), imagery/distraction techniques, relaxation exercises , biofeedback, breathing exercises, music therapy, massage, TENS, hot/moist compresses or cold compresses.

A record review and staff interviews identified the resident had ongoing complaints of pain in their lower extremity. The resident fell again a week later and then again a week later. During this time, the X-ray of the lower extremities remained outstanding and interventions to determine the appropriate pain management methods were not assessed.

Several weeks after the initial order for the X-ray the report was received, and the

resident had a significant injury to their lower extremity and was sent to the hospital.

An interview with Registered staff confirmed an unawareness of the plan of care requiring the need to determine appropriate pain management methods.

The resident passed away a few weeks after being sent to the hospital after the x-ray results revealed the need to be transferred.

The licensee failed to ensure the care set out in the plan of care was provided to the resident when a lack of appropriate pain management methods with a painful lower extremity that was later determined by X-ray to be a significant injury.

Sources: STL diagnostic imaging report, resident post-fall checklist, Referral to Fall Prevention Focus Group form, written care plan, Prescribers Digiorder, Fall incident risk management report, progress notes, point click care pain level summary. PSWs #107, #110, #112, RPN #109, #111, RN #105, PACS administrator StL imaging. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the plan of care set out clear directions to staff and others who provide direct care to the resident and to ensure the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10, s. 49 (2) required the licensee to ensure that when a resident has fallen, the resident was assessed and, if required conduct a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of the homes' fall prevention policy failed to include reference to a clinically appropriate assessment instrument that is specifically designed for falls and when this instrument was required to be completed post-fall.

Registered staff interviews revealed that after a resident's fall they complete head to toe, skin, pain, head injury assessments. The staff shared they also complete a Risk Management incident report template and a Falls Risk Assessment but were unsure of the clinically appropriate assessment instrument that is specifically designed for falls.

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

Ontario Regulation 79/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The homes' 'Falls Prevention and Management' policy included directing registered staff

to conduct an incident investigation and complete an Incident Report and Fall Risk Assessment. Further, staff were directed to analyze data to identify potential root cause (s) and modifiable factors for falls. To review and revise current fall prevention strategies to mitigate risk for future falls in collaboration with the interdisciplinary team.

Resident #001 fell and sustained a significant change in status A review of the Risk Management Incident report completed by RPN #104 identified the predisposing factors to the fall but failed to identify the resident's clothing placement while self transferring and toileting needs as possible causes of the fall. An interview with the RPN revealed they were unaware that the resident's clothing was soiled, or that the resident was dressed in a manner than could have contributed to being unsafe when self-transferring. The RPN also stated they were unaware that four bed rails were raised, at the time of the fall, when the plan of care revealed two. The RPN stated they focused on assessing the resident for injury and only meet with PSWs to review the fall when the resident has fallen three times.

An interview with resident #001's SDM revealed that after the resident returned from the hospital, on two occasions the resident was dressed and clothing was placed in a manner that was unsafe if the resident would self ambulate.

The home's 'Falls Prevention and Management' program failed to reduce the incidence of falls and the risk of injury by the lack of investigating contributing factors, the provision of resident #001's clothing and toileting needs, at the time of their fall as possible predisposing factors to the cause of the fall with the aim to reduce the incidence of falls and the risk of injury.

Sources: Policy #RC -4.7 Falls Prevention and Management Program, dated July 2021, point click care (PCC) assessments including Fall Risk Assessment. Risk Management Incident reports. Staff and family interviews. [s. 8. (1)]

2. Resident #006 fell three times in November 2021 and passed away December 3, 2021.

After the November 13, 2021, fall the resident had pain in their left knee, later diagnosed by X-ray on November 23, 2021 as a left knee fracture.

A review of the Risk Management Incident report from the resident's November 18, 2021,

fall documented the resident’s leg weakness and pain from November 13, 2021 fall as possible root cause but failed to address the resident's pain. The resident care plan focused on pain management created after the resident’s November 13, 2021’s fall had not been implemented. The resident fell again November 22, 2021.

The home's 'Falls Prevention and Management' program failed to reduce the incidence of falls and the risk of injury by not addressing resident’s left knee pain as the potential contributing factor to the cause of the fall November 18, 2021 as resident fell again November 22, 2021. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

Issued on this 20th day of May, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l’inspection :	2022_595110_0003
Log No. / No de registre :	015312-21, 016095-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 2, 2022
Licensee / Titulaire de permis :	Mon Sheong Foundation 36 D'Arcy Street, Toronto, ON, M5T-1J7
LTC Home / Foyer de SLD :	Mon Sheong Scarborough Long Term Care Centre 2030 McNicoll Avenue, Scarborough, ON, M1V-5P4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Alan Hui

To Mon Sheong Foundation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with s. 3. (1) 1 of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

1. Provide education to all staff on the grounds identified in this order.
2. Upon receipt of this order, conduct random audits over the next month, to ensure this night shift practice has stopped.
3. Provide written evidence of steps 1 and 2 to be provided to an Inspector upon follow-up.

Grounds / Motifs :

1. The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

A Critical Incident was submitted to the Ministry of Long-Term Care reporting resident #001's fall.

An interview with the Personal Support Worker (PSW) who responded to the fall, around 0700hrs, described how the resident was dressed. The resident had a t-shirt, brief and pants that were placed to just below their knees. The PSW shared that night staff placed pants on residents to below the knees to assist day staff in dressing residents and getting them up for breakfast. The night shift PSW confirmed this practice.

The Inspector conducted random observations between 0648hrs and 0703hrs one morning with PSWs and identified residents #002, #003, #004, #005 and #006 in bed with their pants placed to just below their knees.

The licensee failed to ensure the residents are dressed in a manner that respects their dignity.

Sources: PSWs #100, #103, #120 interviews and resident observations.

An order was made by taking the following factors into account:
Severity: There was minimal harm or potential for actual harm.
Scope: The scope of this noncompliance was widespread as at a minimum three out of three residents were impacted.
Compliance History: The licensee has had one or more unrelated non compliance in the last 36 months.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5. of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:
1. Immediately stop the PSW practice of residents pants being placed below the knee while in bed.
2. Educate registered staff to investigate and identify potential root causes and modifiable safety risks while conducting post fall assessments, according to the home's Fall Prevention and Management policy.
3. A record of the education provided shall be made available to an Inspector upon follow-up.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting resident #001's fall on September 24, 2021 around 0700hrs resulting in a right pelvic fracture and a 2 centimeter (cm) x 3cm hematoma with skin abrasion near the resident's left eyebrow.
A record review and staff interviews revealed the resident was new to the home and at risk of falling as they had had a prior fall before being admitted on September 1, 2021.

On September 24, 2021 a PSW heard and responded to the fallen resident and stated the resident was on the floor, in their room, wearing a t-shirt, brief and pant that were placed just below their knees. The PSW stated night staff, on

their last round, placed pants to below the resident's knees to assist day shift staff in dressing residents in time for breakfast. An interview with the night PSW confirmed that around 0600hrs tht morning when they changed the resident's brief, they placed their pants on to their knees.

An interview with the Physiotherapist (PT) described resident #001 as being able to get up from their bed. The PT stated the practice of restricting movement with pants being placed to the resident's knees was unsafe for this resident.

Interviews with RN #105 and the DRC confirmed awareness of the night staff practice and provided a November 12, 2021 shift report documenting education around this practice. An interview with RN #015 confirmed that they had gone to each floor to educate night staff to stop the practice.

On February 8, 2022, the Inspector conducted observations between 0648hrs and 0703hrs and identified residents whose pants had been placed to just below their knees. The residents included #004 and #005, at risk of falling, according to their plan of care. A follow-up interview with the PT confirmed that this practice for the identified resident's would be a safety concern as both residents could attempt self transferring and with their mobility restricted, by the placement of their pants, increase their risk of falling.

Sources: observations, PSW, registered staff and PT interviews, progress notes, written plan of care.

An order was made by taking the following factors into account:
Severity: There was actual harm and risk identified when residents at risk of falling had pants placed below their knees, restricting their movement.
Scope: The scope of this noncompliance was widespread as three out of three residents were impacted.
Compliance History: The licensee has had one or more unrelated non compliance in the last 36 months.
(110)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 08, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 2nd day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Diane Brown

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