Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2019	2019_779641_0022	014368-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Hastings
235 Pinnacle Street P.O.Bag 4400 BELLEVILLE ON K8N 3A9

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

Hastings Centennial Manor
1 Manor Lane P.O. Box 758 BANCROFT ON K0L 1C0

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

CATHI KERR (641)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 26, 27, 2019 and August 28, 2019 off site.

This inspection was conducted in reference to intake log #014368-19, critical incident #M537-000014-19 related to a resident falling when left alone in a lift.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Practical Nurses, and Personal Support Workers. During the course of the inspection, the Inspector reviewed resident care and services, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes and policies and procedures related to transfers and lifts.

**The following Inspection Protocols were used during this inspection:
Personal Support Services**

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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 failed to ensure that staff used safe transferring and positioning techniques when assisting resident #001.

On a specified date, resident #001 had been clipped to a lift by PSW #102, who then left the resident alone to go search for someone to assist with the transfer. When the PSW returned to the room, resident #001 was found sitting on the foot rest of the wheelchair, still attached to the lift. The resident complained of pain in several areas. The resident received x-rays and the resident had not sustained a fracture.

During interviews with Inspector #641 on August 26 and 27, 2019, PSWs #103, #105 and #106, and RPN #104, indicated that the staff must have two people with a resident when they were connected to a lift, for the resident’s safety. The PSWs advised that the staff received training on lifts on a regular basis and that the safe use of the lift was part of this training.

During an interview with the Inspector on August 26, 2019, the Director of Nursing (DON) indicated being familiar with the incident that had occurred on a specified date where resident #001 had fallen when left alone while attached to a lift. The DON advised that the licensee’s policy indicated that all transfers with mechanical lifts must always be performed by two staff and that this included attaching the resident to the lift. The DON specified that PSW #102 had received mandatory lift training which included the requirement that a resident could not be connected to a lift without two people in attendance, as this was part of the process for transferring a resident.

The licensee’s policy H-265, Transfers and Lifts, page one, under Preamble stated: All resident lifts must be performed by two or more staff including a mechanical lift. On page six of the same policy, under Mechanical/Ceiling Lifts/Bath Chair stated: One staff is responsible to ensure the sling is attached correctly. One staff is responsible to be the spotter. Two staff must be present when using any of these lifts with a resident.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 29th day of August, 2019

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

Original report signed by the inspector.